UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

VINCENZO MAZZAMUTO, : Plaintiff : CIVIL ACTION - LAW
: Versus : NO. 1:CV-01-1157
UNUM PROVIDENT CORPORATION; PAUL REVERE LIFE INSURANCE COMPANY; and NEW YORK LIFE INSURANCE COMPANY, : Defendants : JUDGE KANE : JURY TRIAL DEMANDED

DEPOSITION OF DOUGLAS JOHN BOWER

* * *

Verbatim transcript of deposition held at 220 Wilson Street, Carlisle, Pennsylvania, on Wednesday,

March 6, 2003
3:22 p.m.

* * *

APPEARANCES:

ANGINO & ROVNER, P.C.
4503 North Front Street
Harrisburg, PA 17110

BY: RICHARD C. ANGINO, ESQUIRE

For - Plaintiff

STEVENS & LEE
111 North Sixth Street
Post Office Box 679
Reading, PA 19603-0679

BY: KIRK L. WOLGEMUTH, ESQUIRE

For - Defendants

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STIPULATION

It is hereby stipulated by and between counsel for the respective parties that signing, sealing, certification and filing are waived.

MR. SIMMERS: My name is Arkie Simmers. I'm a paralegal with Angino & Rovner. Our offices are located at 4503 North Front Street in Harrisburg, and I'm operating the video and audio equipment for today's deposition.

The date is March 26, 2003, and it 3:22 p.m. We are here on behalf of the plaintiff to take the deposition Doctor Douglas J. Bower at 220 Wilson Street at Carlisle, PA. Doctor Bower will be testifying in this case Vincenzo Mazzamuto versus Unum Provident Corporation, Paul Revere Life Insurance Company, and New York Life Insurance Company in the United States District Court for the Middle District of Pennsylvania, No. 1:CT- 01-1157.

Will the attorneys please introduce themselves and who they represent.

MR. ANGINO: My name is Richard Angino, and I represent Mr. Mazzamuto.

MR. WOLGEMUTH: My name is Kirk Wolgemuth, and I represent the Defendants, Unum Provident, Paul Revere and New York Life.

Exhibit A

MR. SIMMERS: Will be court reporter please swear in the witness.

DOUGLAS JOHN BOWER,
being duly sworn,
testified as follows:

DIRECT EXAMINATION

BY MR. ANGINO:

Q What is your full name?

A Douglas John Bower.

Q What is your office address?

A 220 Wilson Street, Suite 109, Carlisle, Pennsylvania.

Q Are you a physician?

A Yes, I am.

Q And can you tell us just briefly about where you went to college and medical school, and did your internship and residency?

A Okay. I went to undergraduate and medical school at Boston University, Boston, Massachusetts. I did my internal medicine residency and internship at the Naval Hospital in San Diego, and served in the Navy as an internist for nine years prior to joining the practice here.

Q As far as dates, would that have been college done in 1984, medical school done when?

A College 1976 to 1980. Medical school 1980 to 1984. Internship 84 - 85, and residency 86 to 88.

Q And when you completed all of that, were you board certified in any particular specialty?

A I was board certified in internal -- I am board certified in internal medicine as of September of 1988.

Q Could you tell the jury what internal medicine is?

A Internal medicine is the nonsurgical -- treatment of nonsurgical diseases of adults usually in terms of things such as arthritis, diabetes, heart disease, lung disease. It also now encompasses primary care, which is, again, basically the general care of patients as their first provider.

Q And with what medical association are you currently a partner?

A I'm a partner at the Masland Associates.

Q Located in?

A In Carlisle, Pennsylvania.

MR. ANGINO: Any questions as to qualifications?

MR. WOLGEMUTH: I will reserve what few I have for cross.

Before we continue, just so we know for the record, any objections we will stop the videotape and we will place them on the transcript.

MR. ANGINO: That's a good idea. We don't want to waste any more video than we need to.

BY MR. ANGINO:

Q Doctor, with regard to Masland, when did you first begin your practice here?

MR. ANGINO: Do we have DND, do not disturb kind of thing?

MR. SIMMERS: Off the record.

(Off the record.)

MR. SIMMERS: We are back on the video record. The time is 3:26 p.m.

(On the video record.)

BY MR. ANGINO:

Q Doctor, with regard to your practice at Masland's, when did that start?

A December of 1993.

Q And did you shortly thereafter have as a patient Mr. Mazzamuto?

A Yes, I did.

Q Can you tell us as far as your practice whether there is any emphasis or at least

preponderance of individuals as far as age and chronicity of their complaints?

A Well, in internal medicine most of our patients tend to be older and even elderly. We see many patients with chronic medical conditions, again, such as blood pressure, arthritis, diabetes, heart disease. So the majority of our patients, and, in fact, most of our reimbursement is actually of the Medicare age group. You know, we do see younger patients as well, but I would say the majority of our patients are older patients with chronic disease management.

Q You don't deliver babies or take care of children, and things like that?

A We do not deliver babies, we don't take care of children. We don't do major surgical procedures.

Q So that of the things that you do do, you do a lot of that, is that right?

A That is correct.

Q Would one of the areas that you see a number of patients be the area of the back and back complaints?

A Low back pain is a very common problem in seeing chronic -- in many older people.

Q And are you able to diagnosis back conditions?
A We often are the people who diagnosis back conditions that leads -- initiate treatment.
Q So that you not only would diagnosis the back condition, you would initiate treatment, and if sometimes they get complicated or if they need surgery, then do you refer them to specialists?
A Yes. We refer on to surgical specialists, either orthopedists or neurosurgeons, as well as the allied health field such as physical therapy.
Q With regard to these older patients, do they sometimes have conditions such as anxiety, and depression, and emotional problems?
A Sure. It's very common.
Q And do you take care of them?
A Yes, we do.
Q Do you likewise diagnosis and medicate them?
A Yes, we do.
Q And, again, if the condition gets to be severe, do you refer them on occasion?
A We do refer on occasion although mental health assets in central Pennsylvania are not easy to come by. There are not many psychiatrists in

this area, so we do a lot of the primary management of psychiatric problems with traditional antidepressant and antianxiety medications.
Q Thirdly, I assume if people who are older, many of them have heart conditions, is that right?
A Very common, yes.
Q And, again, you diagnosis and treat them, is that right?
A Yes we do. Yes, I do.
Q And, again, if there are situations such surgery or certain kinds of specific tests, you refer them on to other people?
A We refer to the cardiologist for that, that's correct.
Q With regard to Mr. Mazzamuto, did he develop a back condition back in 1996?
A Yes, he did.
Q And do you have your records?
A I have my records with me, yes.
Q With regard to Mr. Mazzamuto, was he in 1996 sent for what they call an MRI?
A Yes, he was.
Q And I am handing you what we will mark as P-1.

Copy of document entitled Carlisle Hospital and Health Services, Department of Radiology, Carlisle Imaging Associates, P.C., dated 06/05/1996 - produced and marked for identification as Exhibit No. P-1.

MR. ANGINO: What we can do is with regard to these we will mark them after we are done. Is that satisfactory if we go through them?
MR. WOLGEMUTH: Okay. I'm going to place an objection on the records. Can we go off the video.
MR. SIMMERS: Yes. Off the video record. The time is 3:30 p.m.
(Off the video record.)
MR. WOLGEMUTH: I'm going to do this now, Richard, so I don't interrupt you later.
I certainly don't mind him referring to these exhibits, and testifying from exhibits, and, you know, if he relied upon them, he can -- but I don't want them attached to the transcript as an exhibit. I believe the only one that I would not object to attachment would be the portion of the Attending Physician's Statement, not the November 3, 2000 report, and I guess it's an Attending Physician's Statement dated it looks like 8/29 --

I'm not sure what that is, 00 or O1.
MR. ANGINO: What we will do is your objections are noted. When we get to Court, it's not so much being attached to a deposition, we are going to be at trial, so the Court will have to make a decision. The Judge will have to make them a part of the record. Whether he would let the jury see them or whether they would go out with the jury will be decisions that he will make.
MR. WOLGEMUTH: That's fine.
MR. ANGINO: All right. Back on the record.
MR. SIMMERS: Back on the video record. The time is 3:31 p.m.
(On the video record.)
BY MR. ANGINO:
Q Doctor, within your file did you have what is noted as P-1, a Carlisle Hospital, Department of Radiology, MRI?
A Yes, we did.
Q And can you, first of all, by stating what is radiology, and what is an MRI?
A Well, radiology is a field of medicine which attempts to obtain images of internal body structures through various means. You can use

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x-rays, you can use sound waves, which is called ultrasonography, or you can use MRI, which actually uses the body's own magnetic emanations under the field of a magnet field to obtain computerized reconstructed pictures of internal body parts.

Q And as a result of complaints that Mr. Mazzamuto was having with respect to his back, did you refer him to a specialist in radiology?

A Yes, we did.

Q Is this customary in your profession to refer individuals to radiologists, and to reply upon the reports that you get back?

A Yes. As the field of radiology has gotten more and more complex, the studies are more and more difficult to read for people who don't do it on a regular basis, so, therefore, I find that I need to rely upon the expertise of the radiologists for their readings of complex films such as CAT scans ultrasounds, and MRIs.

Q With regard to those reports, do you rely upon them in your treatment as to medications, and how you treat particular patients?

A I rely upon them for all those things.

Q With regard to what's been marked as P-1, could you start with the second full paragraph,

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there is spinal stenosis, and just read that paragraph were the impression please?

A Okay. There is spinal stenosis. The AP diameter of the canal is smoothly and considerably narrow, and this is most prominent at the L3-4 disk level. There is no significant disk herniation or bulging, and this is thought to be due to developmental stenosis rather than to disk herniation or hypertrophic changes of the facet joints. The stenosis gradually dissipates above and below these levels. The cerebral spinal fluid in the area of the stenosis does not appear bright. This is probably due to the relative lack of fluid, with crowding of the nerves roots, as well as loss of fluid signal due to increased flow to this area due to the stenosis. No focal intrathecal mass is seen. Marrow signal was normal.

Impression. Central spinal stenosis which gradually worsens to a maximum at the L3-4 level. This probably extends from L2 though approximately the L5 vertebral body levels.

Q All right. Doctor, on your desk is a spine. Could you use it to tell the jury what part of the anatomy we are dealing with, and perhaps if you can explain what disks are, and what the various

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vertebral bodies are, and the spinal cord, things such as that?

A Okay. Well, this is a model of the lower part of the spine. The spine is divided into several spots -- parts. The neck is the cervical spine, in the chest it's the thoracic spine, the lower back is the lumbar spine, and the very bottom, which is called the tailbone, is also the sacrum, which is actually five vertebrae fused together into one.

You know, the spine is put together by a series of vertebral bodies, individual bones, which are held together by a disk and various ligaments in the back.

Now, the disk is here, this robbery component, in between the two bony bodies of these vertebrae. This is the first lumber vertebra, this is the fifth lumbar vertebra, and the numbers are sequential.

The disk serves as a space or point of attachment for the spine. It's a tough fibrous band circumferential with a gelatinous core, acts as sort of a shock absorber. You know, back pain can come from the disk if the disk is degenerating. If it ruptures, the core of -- the gelatinous core can

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sometimes protrude through the rupture of the fibrous outside, and actually impinge on the spinal cord or the nerve endings. So that's one cause of low back pain, and that's one of the reasons we get MRIs, is to see if a disk is ruptured. In Mr. Mazzamuto case that was not the case.

The spinal cord actually runs behind the large bodies of the vertebrae within an arch that's made up of bony prominences coming from two sequential vertebrae. You have the spine off the back, and you have the lateral portions of the next vertebra forming a canal, which, if you look at it on end, you can see there's a space where the spinal cord runs.

Q Is that red thing the spinal cord?

A That's the -- it's a yellowish -- yellowish --

Q Okay.

A -- robbery model here.

If there is spinal stenosis, what it means is that this canal here behind the body of the vertebrae becomes narrowed, and that could become narrowed for several reasons. They talk about it in there. One is congenital, meaning the when the spine was formed it's was just more narrow than

normal, and that can actually progress as times go on.

The second thing that could happens is these joints here where the two vertebrae come together can get arthritis, and bony growth around them can occur, and so you can get spinal stenosis coming in from this arthritis section, and, again, they say it doesn't appear that Mr. Mazzamuto has that.

So those are the two kinds of spinal stenosis, and I believe this is red thing here is a herniated disk that they put on there. I didn't notice that was there.

Q Where would 3 and 4 be, which is what they -- the Doctor says is the maximum?

A Well, the maximum is between these two vertebrae, this is 1, 2, and this is 3, and then this is 4. And, again, usually -- if you notice the nerves emerge from the spaces between two contiguous vertebral bodies. So if you have L3 here, the space where the nerve comes out is L3-4, which is the space in between those two, and so this is the level where he sees a narrowing in the spinal canal.

Copy of document entitled Normal Canal and Stenotic Canal - produced and marked for identification as Exhibit No. P-2.

Q Doctor, I'm showing you P-2, and can you tell us what that is?

MR. WOLGEMUTH: Objection.

MR. SIMMERS: Off the video record. The time is 3:38 p.m.

(Off the video record.)

MR. WOLGEMUTH: I'm going to object to P-2 in addition to the previous objections that I raised because, unless this is representative or an actual picture of the extent of Mr. Mazzamuto's stenosis, I don't think it's relevant to this proceeding. I think Doctor Bower already adequately described what spinal stenosis is.

MR. ANGINO: Go on the record.

MR. SIMMERS: We are back on the video record. The time is 3:38 p.m.

(On the video record.)

BY MR. ANGINO:

Q Doctor, I'm showing you P-2. Can you tell us what that is?

A All right. That's a picture -- a transverse section.

Q Do you want to show it to the jury please?

A Okay. Basically it's a transverse section of the spinal cord. Essentially if you took the spine, put it like this, and chopped it off, so you can get an end on look at the spine, you are looking at the top of a vertebral body.

Q And does it show an example of a spinal stenosis?

A Yeah. This is the normal spinal canal here, and a stenotic canal would look something like that in this particular case. It's a narrowing of that canal opening.

Q And, Doctor, are you meaning to imply that that's the exact size of Mr. Mazzamuto or is it just an example of how a spinal stenosis can show narrowing of what is a normal spine?

A This is just a general example of a spinal stenosis. It is not a representation of Mr. Mazzamuto's spine.

Q Doctor, with regard to spinal stenosis, does that generally lead to back pain?

A It generally does when it progresses beyond a certain point.

Q And do you have a spine diagram or picture?

A We have several.

Q You have several. Can you show us how this leads to pain?

A Well, again, I'm not -- probably this would be a better one to look at. Again, as -- what we are looking at here, as we are looking at the spine with basically these posterior elements cut off so you can actually look down directly onto the spinal cord as it sits in front of the vertebral bodies, the spinal cord sits within this canal, nerve roots emerge in between each of the spinal sections. If there is a narrowing of this canal, again, as we described before, this space gets narrower, the canal -- or the spinal cord can actually become impinged by that pressure, and obviously bending of the spine can lead to increasing pressure as the forces are exerted upon it because of the bend and the curve in the spine.

So the spinal cord is what normally gets impinged upon rather than the nerves roots themselves. There can be narrowing of these holes as well on the side, in which case the nerve endings as they came out would also be impinged upon.

Q In addition to having back pain, can you also have what we call leg pain?

A Yes. When you have a nerve that's impinged, you can have symptoms anywhere that nerve goes, and in the lower part of the back the nerve roots that emerge from the spine at that point eventually form the nerves, and go down the leg. So you if you have compression of either the spinal cord or the nerve endings as they emerge for the particular nerves that form the femoral nerve and other nerve, the sciatic nerve, that goes down the leg, you can get pain along the entire tract of that nerve, and you can also get muscle weakness because nerves not only provide sensation, they also provide the control for the voluntary muscles as well.

Q So you can get muscle weakness, you can have pain. Can you get burning pain?

A Well, you can get any pain that you can imagine. The nerves are the sensation. You know, typical pains that people describe when it's actually a nerve pain, which is call neuropathic pain, would be burning, stinging, it can be icy cold, it can be numb, you know, or as I say here, jaggy.

Q So if somebody who has a spinal stenosis complains of back pain and/or burning pain and/or numbness, is that telling you as a Doctor that

there's impingement upon the spinal cord and/or the nerve roots that emanate from the spinal cord?

A That's a sign that there's a nerve impingement somewhere in the system.

Q And with regard to Mr. Mazzamuto, do your records show that starting in the period of 1996 he started to complaint of all of what we have just described, back pain, radiating numbness, radiating burning pain into his legs?

A Yes, they do.

Q And with regard to that, did there come a time in 1996 where this pain was of such an intensity that he was disabled from work?

MR. WOLGEMUTH: Objection.

MR. SIMMERS: Off the video record. The time is 3:43 p.m.

(Off the video record.)

MR. WOLGEMUTH: My objection is to relevance because I really don't think that Mr. Mazzamuto's disability in 1996 is relevant to the issues that are raised in 2000.

MR. ANGINO: Back on the record.

MR. SIMMERS: Back on the video record. The time is 3:43 p.m.

(On the video record.)

BY MR. ANGINO:

Q Doctor, there is a packet of materials starting with 1996 Attending Physician's Statements. Do you have such a packet in front of you?

A Yes I do.

Q And did that packet come from your file?

A This is a copy of a packet from forms that were from our file, yes.

Q And we have marked that as P-3.

Copy of packet of documents beginning with Attending Physician's Statement for Vincenzo Mazzamuto - produced and marked for identification as Exhibit No. P-3.

Doctor, is it customary in your particular profession when a person has a condition that is disabling that you get paperwork from insurance companies to complete?

A Yes, that's a very common thing.

Q And with Mr. Mazzamuto back in 1996, did you receive material that you needed to complete under the heading Attending Physician's Statement?

A Yes, I did.

Q And is the date there 10/23/96?

A Yes, it is.

Q With regard to that attending statement, is that your handwriting?

A Yes, it is.

Q And with regard to the diagnosis that you made back in 1996, what was it?

A It was number one, low back pain, and number 2, central spinal stenosis.

Q What you have just been describing to us, is that right?

A That is correct.

Q And when you go through the physician statement, does the insurance company ask you questions such as medications that the patient is taking?

A Yes, they do.

Q And what type of medication was Mr. Mazzamuto taking back in 1996?

A At that point he was on a medication called Relafen, which is an -- what's called a nonsteroidal antiinflammatory medication. It helps with both inflammation and pain, usually helps with an arthritic and bony conditions. He was also on Gabapentin, which goes by the brand name of Neurontin, which is actually a seizure medication, but is now used commonly as an adjunct to pain,

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especially neuropathic pain, pain that comes from nerve injury or compression.
Q Were you asked when his symptoms first appeared, and did you supply dates for them?
A Yes, I did.
Q And what did you indicate as far as when his symptoms first appeared?
A That they first appeared for this episode in January of 1996, and then again in March of 1996.
Q And is there a place for you to complete where it says when patient first consulted you?
A Yes, and that was April of 1996 when he came in with those complaints.
Q And is there another point where it says has patient ever had same or similar conditions?
A Yes, there was.
Q And what did you mark for that?
A I wrote that, when I had reviewed the record, he had been seen for low back discomfort in 1992, and it had subsequently resolved.
Q And is there a question as to whether the patient was still under your care for the condition -- the back condition?
A Yes.
Q And did you mark that with a yes?

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A Yes, I did.
Q And did you mark the date that he was last treated?
A Yes. As of that form it was as of October 23, 1996.
Q Is there question No. 10 that asks about restrictions or limitations?
A Yes, there is.
Q And what was your restriction or limitation?
A At that time it was just no prolonged standing.
Q So that as far as your medical opinion at that time you felt he shouldn't stand for long periods, is that right?
A Correct.
Q And what happens to someone with this type of condition, this stenosis, when a person stands?
A Well, depending upon your posture, when you stand, you can actually have, again, as you straighten the spine out, standing upright can sometimes cause further compression. Now, depending upon what the actual extent of the stenosis is, and what the actual orientation when you would look at it, different postures may affect it differently,

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and in some people standing bothers them, in some people bending bothers them, and in some people both of them bother -- you know, both positions can bother people.
Q Was there a question No. 13 where they asked if Mr. Mazzamuto was continuously totally disabled?
A Yes, there was.
Q And did you find that he had been continuously totally disabled?
A I did.
Q From what period to what period?
A From April 3 of 1996 to October 23 of 1996.
Q And is there a second page to that -- actually not a second page, but did you likewise complete another one on 11/18/96?
A Yes, I did.
Q And with regard to that Attending Physician's Statement of Disability, was your diagnosis the same, low back pain, central spinal stenosis?
A Yes, it was.
Q And was there a question 3 where it said what are the subjective and object -- subjective

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symptoms and objective findings, and what did you answer?
A I answered that there was. He had low back pain, intermittent numbness of both lower extremities as the subjective of the symptoms, meaning the symptoms that the patient themselves report, and objective symptoms, which are things that are demonstrated on the physical examination or on tests, is that he diminished strength in both legs, and that he had had an MRI which documented the central spinal stenosis.
Q So that before when I was asking you general questions, he had the pain, he had the numbness, and he had the weakness, is that right?
A That is correct.
Q So all the signs that one finds with nerve impingement he was demonstrating as long ago as 1996, is that right?
A That is correct.
Q And in terms of treatment and progress, did you note on the record when you treated him, and did you note under progress that he had improved?
A Yes, I did.
Q And when they ask you about the extent of his disability, did you say that he was no longer

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disabled? Is that what it is?
A That as of October 23 he was no longer disabled, correct.
Q So this was a period of total disability that had gone from the period that you had indicated, which was April through October, is that right?
A That is correct.
Q The next particular document that you have there as a part of this packet of material is it a letter dated November 3 of 2000?
A Yes, it is.
Q So that there's a gap of time of four years, and during that four year period of time had Mr. Mazzamuto returned to his work?
A Yes, he had.
Q Did he continue, however, to have back pain, and did he continue to obtain injections for that back discomfort?
A Yes, he did.
Q So that with something such as this spinal stenosis it doesn't go away, is that right?
A The spinal stenosis itself does not go away.
Q And although there may be improvements at

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times, what is the progression of stenosis over time?
A Generally the stenosis gets worse over time with aging.
Q And was that the case with Mr. Mazzamuto?
A That is the case.
Q And in the year 2000 on July 22 did Mr. Mazzamuto have a heart attack?
A Yes, he did.
Q And following that heart attack did he have, again, problems with his back?
A Yes, he did.
Q And in addition to having the heart attack and problems with his back, did he develop emotional problems?
A Yes, he did. He developed severe anxiety.
Q And as had occurred in 1996, were you requested to supply information from his disability insurance carrier as to his condition?
A Yes, I was.
Q And did you do that by way of letter dated November 3, 2000?
A Yes, I did.
Q And was that letter addressed to Paul Revere and New York Life Insurance Company?

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A Yes, it was.
Q And did you -- would you read the first paragraph please?
A Dear Sir or Madam.
I'm writing this letter to clarify the medical facts of my patient, Vincenzo Mazzamuto, who apparently has policies with your companies. I find it difficult to coherently fill out the forms on his medical-- since -- as his medical problems are several, some of which are long-standing and do not easily fit into the category such as when did symptoms appear. Mr. Mazzamuto has had a long history of low back pain, and, in fact, for many years has undergone numerous treatments and physical therapy, and an MRI in the past did reveal central spinal stenosis, which gradually worsened to a maximum at the L3-L4 level and extends from L2 to L5. This has given him periodic problems with lower back discomfort, symptoms of radiculopathy, and urinary irritability.
Q Can you tell us what radiculopathy is?
A Radiculopathy is another term that a nerve going down -- down a limb is being affected.
Q And what about urinary irritability?
A Urinary irritability he was seen for

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several occasions because of the sensation that he couldn't empty his bladder completely, and had to go frequently.
Q Continue with the paragraph please.
A Prolonged standing and heavy lifting has aggravated it. He has been seen in physical therapy, treated in a local pain clinic with local injections, as well as prescription analgesics, nonsteroidal antiinflammatory agents, and other atypical chronic pain medications.
Q And did you mention then in the second full paragraph the complication of the heart attack?
A Yes, I did.
Q And you described what occurred there?
A I did.
Q And with the third paragraph did you talk about a readmission to the hospital with chest pain?
A Yes, I did.
Q And then would you read the fourth full paragraph please?
A As the patient has attempted to return to work after his recovery from his heart attack, his back worsened again. Also the stress and anxiety which has been provoked because of his recent cardiac problems, and manifested themselves with

significant anxiety when he is back in a work situation.
Q Can you read the next paragraph please?
A Sure. While his heart condition has currently stabilized, and should hopefully not pose a great limitation to him in the future (assuming ongoing risk factor modification is successful, such as smoking cessation, cholesterol lowering, et cetera), the amount of weight he has gained from his smoking cessation has re-exascerbated his chronic and progressive back problem. At the present time he is not able to do the work required in running his restaurant because he cannot stand for long periods of time, has difficulty bending, and is restricted from heavy lifting. It is unlikely he will be able to return to work in the foreseeable future.
Q And then were you asked for a prognosis?
A Yes, I was.
Q And what did you say?
A His prognosis for recovery is fair over the next six to twelve months.
Q How about the next paragraph?
A On his last visit of October 4 he weighed 206 pounds, his blood pressure was 112 over 80, his

pulse was 48 and regular. He was proceeding with his cardiac rehabilitation program and was to follow-up at the pain clinic for further symptomatic treatment of his back. At the present time the patient has not achieved a medical plateau. It is my hope that once his weight stabilizes after his smoking cessation -- after his smoking cessation is consolidated, and he has completed his cardiac rehabilitation, he may be able to attempt weight loss, and hopefully improve his back situation in the future.
Q And the next paragraph?
A The final results of this may not be evident, however, for the next six months.
Q In addition to sending a letter on November 2, were you asked to complete a form, which is the next part of the packet, which carries the date of November 15, 2000?
A Yes, I did.
Q And is it in a similar form to the other form that you had completed back in 1996?
A Yes, it is.
Q And with regard to that particular form, did you state that he continued to be totally disabled?

A Yes, I did.
Q As to paragraph 16, did you indicate what his current restrictions were?
A Yes, I did.
Q And what were they?
A Cannot be in stressful situations, no prolonged standing, no lifting.
Q Doctor, the next page is that, again, another form that you completed?
A Yes, it is.
Q And with regard to these forms, do you routinely get them either monthly or bimonthly, and do you complete them, and send them back to the insurance company?
A Different companies seem to have different intervals at which they require them but, yes, we get them repeatedly to sort of keep up with the ongoing situation, and we fill them out and send them back.
Q As the years went by since the year 2000, has Mr. Mazzamuto's condition worsened?
A His back situation has worsened.

Copy of document entitled Fig. 2: Posture typical of a patient with Spinal Stenosis - produced and

marked for identification as Exhibit No. P-4.

Q And with regard to the worsening of his back condition, has he started to developed more of what we call a stoop, and I'm showing you another exhibit?
MR. WOLGEMUTH: Objection.
MR. SIMMERS: Off the video record. The time is 3:57 p.m.
(Off the video record.)
MR. WOLGEMUTH: Again, I think this picture is not representative of Mr. Mazzamuto's posture. I don't think it's relevant to his testimony, and I think it's inflammatory.
MR. ANGINO: Back on the record.
MR. SIMMERS: Back on the video record. The time is 3:57 p.m.
(On the video record.)
BY MR. ANGINO:
Q Can you hold the picture up, Doctor, and tell us, although Mr. Mazzamuto is not as pronounced yet as this particular individual, has he through the past three years begun do develop more and more of a stoop?
A He does have a stooped posture.

Q What causes a stoop in posture, Doctor?
A Well, usually, again, as I had mentioned earlier, depending upon the exact anatomy of the stenosis, people are going to try to find the most comfortable position to relieve the pressure on the spinal cord or the impinging nerve, and usually by curving forward slightly you can relieve some of that pressure to a point.
Q Doctor, approximately a year ago were you requested to provide an update of Mr. Mazzamuto's condition, and did you do that by way of letter of April 16, 2002?
A Yes, I did.
Q And I'm marking this as P-4?
MR. WOLGEMUTH: P-5.
MR. ANGINO: P-5.
Copy of letter dated April 16, 2000 to Mrs. Trudy McGraw, The Wellington, from Douglas J. Bower, M.D. - produced and marked for identification as Exhibit
No. P-5.
BY MR. ANGINO:
Q Do you have that in front of you, Doctor?
A Yes, I do.
Q Doctor, perhaps if you would start with the second full paragraph, and it's a short letter,

read it to us please?
A Okay. As I mentioned to you in past correspondence, Mr. Mazzamuto has three primary medical conditions. His first problem revolves around his severe low back pain, which has been chronic and unrelenting despite numerous aggressive interventions. He has been on multiple medications, received therapy from a pain clinic, received local epidural steroid injections, and numerous prescription medications, all with only partial success. Despite this aggressive therapy, Mr. Mazzamuto is still severely limited in his ability to stand, bend, sit for long periods of time, and is unable to work.
His second, and perhaps most severe problem, is that of chronic anxiety and depression. This has become especially manifest over the last several years, and has proved to be somewhat refractory to multiple medications -- medical interventions.
Q What is refractory?
A Refractory means not responding to treatment.
Q Continue please.
A This problem was complicated by his third

problem, which is that of coronary artery disease. As a result of his heart problems, Mr. Mazzamuto is extremely fearful of suffering a heart attack and dying.
At the present time I feel that Mr. Mazzamuto is beings treated maximally, but the combination of the three previously mentioned conditions still renders him unable to work. Because of his severe anxiety, he is unable to even consider the possibility of back surgery, and he's extremely fearful that surgery will either render him paralyzed or induce further myocardial infarction. As such, I do not think it wise to pursue this option. We will continue our efforts with medical therapy in an effort to improve Mr. Mazzamuto's quality of life, but I feel that we have probably plateaued in our abilities to improve his level of function. As such, it has been our recommendation that he not return to work.
Q Doctor, with regard to Mr. Mazzamuto, he's been your patient now for almost ten years, do you know the type of work he does?
A Yes, I do.
Q What type of work does he do?
A He is self-employed. He owns and runs a

restaurant.
Q And, Doctor, are you aware from actually going to his restaurant ten to fifteen times the type of work he does?
A Yes, I am.
Q Did I supply you a copy of a video which shows the type of work he does?
A Yes, you did.
Q Doctor, has Mr. Mazzamuto and Mrs. Mazzamuto also explained to you at different times what he does?
A Yes, they have.
Q Can you tell us what are the things that you have observed or things that you are aware of that make his current condition, the three things that he has, the emotional condition, the back condition, and the heart condition, such that he is unable to work?
A Okay. Well, first, and to keep it simple, the heart condition at this point is probably not relevant, and probably does not contribute at this point to his disability or in his inability to work, so we will focus on the other two conditions.
As regards to his back condition, he runs a basically pizza and sub restaurant. You know,

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there's a counter that you stand at when you order. The food is prepared in a standing position. There's various stations. There's places where you make pizza, places where you make hot food, places where you make subs. It all requires frequent bending, stooping, prolonged standing. Supplies are kept overheard, supplies are kept, you know, underneath. So you are either reaching forward to grab things or you are reaching underneath cupboards and cabinets to grab things.

You know, as a restaurant, most materials that arrive arrive in bulk. You know, these are big jars of things. There are cases of materials. You know, large cans of various commercial grade food items.

So all of those things are basically the antithesis of what Mr. Mazzamuto is currently able to do. He can't stand for prolong periods of time. He can't do a lot of bending. He can't do a lot of lending forward. You know, he cannot do lifting of heavy objects or, you know, putting away heavy objects in storage containers or storerooms, you know, things of that nature.

Q Approximately how long could he stand before he would start to get pain?

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A Well, based on my conversations with him, I think he can normally stand in a particular position maybe ten or fifteen minutes before he needs to change position, and, you know, the thing with that is it's almost a constant need to change positions. He might sit for a period of time, and then need to stand. He might stand for a period of time, and then need to sit. He might sit, and then need to lie down. And so people are constantly shifting position in an effort to try to find some point of maximum relief.

Q And, Doctor, the counter that he stands behind is it about four feet tall?

A Four, maybe slightly higher. Yeah, about that.

Q So it wouldn't be very practical to sit there, and to wait on customers, is that right?

A No, you probably really couldn't sit there, you would be down below the counter level.

Q Additionally, there's not much space there, is there?

A It's a small restaurant, and the work spaces are quite tight and cramped, and there are several people all doing things simultaneously there.

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Q From your observation particular of the video, does it seem to be a fast paced kind of place?

A Especially during, you know, the peak hours of a restaurant, you know, the lunch rush, the dinner rush. There's lots of activity, and a lot of people doing lots of things all simultaneously, and the pace of the work of each of the workers is quite brisk.

Q What about the emotional element? I think you indicated he also has emotional problems, depression, things such as that?

A Well, when he first attempted to go back to work, again, as a small business owner, my observation is that you would sort of have to be involved in all aspects, and he has family members, but he also has employees who work at the restaurant. His past habit had been that if something needed to be done, and nobody was doing it, he could jump in and do it. When he was no longer able to do that, he would get extremely frustrated, he would get angry, he would lose his temper, and that sort of emotional stress would lead to things such as chest discomfort, which fortunately is only his heart, but just a

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manifestation of the stress. It's also promoted him to take back the habit of smoking, which, again, is further damaging to his health down the line. So being in the restaurant when he really couldn't contribute to anything turned out to be something that aggravated his emotional stress and his anxiety levels.

Q Did it even get to a point where he started to have problems outside the restaurant with his wife because of the emotional --

A He ended up with lots of problems both at the restaurant and with his wife. He was irritable, he was grouchy, he would snap at her. He was having lots of difficulty focusing, lots of difficulty concentrating, and, as such, much of the work that he normally would do with the bookkeeping, the paperwork, things like that, I think fell to his wife to pick up the slack, and, you know, the fact that he wasn't doing that made him feel guilty, but at the same time he really wasn't capable of doing it.

Q Would you say that Mr. Mazzamuto is a relatively short man?

A He is a short man.

Q What would you estimate his height, maybe

if you have it?
A I don't have it here. We don't do a good job with measuring people. I would say he's probably about 5-6, but I don't think I have it.
Q So 5-6, and at one point I think you said he weighed like 206 pounds or something?
A He did.
Q And I assume that's what we call obese?
A That is medical obesity, and he's heavier now.
Q Even heavier now?
A He is.
Q So that when somebody has a stenosis, and one has pain, and one then doesn't do much, the tendency I guess is to put on weight, is that right?
A Well, that's true, and, again, if one is not working, and is at home, and is anxious, some people will deal with anxiety by not eating, and some people deal with it by eating, and if you don't have much else to do, and you eat, and you don't have any physical activity, you gain weight.
Q And what effect does this additional weight then have upon the back?
A Well, the weight obviously adds more strain to the back. The weight is, you know, in the

front in the belly, and it pulls everything forward, and puts more torque and more strain on the spine. The spine has to support the weight, and, again, it further aggravates the back pain.
Q So that it's almost like a never ending process, you have got the back condition, you don't do things, you get heavier, more aggravation on the back?
A Do less, get heavier, and it spirals.
Q Doctor, if that column gets narrow enough around the spinal cord, can it actually lead to what we call paralysis?
A It could --
MR. WOLGEMUTH: Objection.
MR. SIMMERS: Off the video record. The time is 4:07 p.m.
(Off the video record.)
MR. WOLGEMUTH: You are asking the Doctor for a speculate opinion that has no applicability to Mr. Mazzamuto.
MR. ANGINO: Well, no, it's not speculative. All the books say that it can lead to paralysis and certain conditions. So all I asked was his opinion if it can, and I'm not -- with regard to the future, the law is clear, he doesn't

have to say, you know, that it's going to happen or probably will happen, but it can. Just like, you know, if you have a head injury, you can have a seizure, you know, if you would wind with certain things, doesn't mean you are going to. So that was the direction of my question.
MR. WOLGEMUTH: Well, my objection is on the record.
MR. ANGINO: Okay.
MR. SIMMERS: We are back on the video record. The time is 4:08 p.m.
(On the video record.)
BY MR. ANGINO:
Q Doctor, I'm not meaning to imply that paralysis is a common thing that can occur with the stenosis, but can it happen?
A It can happen.
Q Doctor, with regard to Mr. Mazzamuto, with your background as his private physician over a period of almost nine years, and having treated him from the time that his back condition developed which resulted in his earlier disability, and the period of time from that earlier disability to the disability that followed in 2000, Doctor, do you have an opinion based upon reasonable medical

certainty as to whether Mr. Mazzamuto is totally and continuously disabled from doing the type of work that he did, which is to own and operate a pizza restaurant?
A Yeah, I feel that he is totally and permanently disabled from the kind of work he has previously done.
MR. ANGINO: You may cross examine.
MR. WOLGEMUTH: What exhibit number are we at, 6?
MRS. STILL: I believe, yes.
MR. WOLGEMUTH: Doctor, I'm going to give you a packet of documents, which are your notes. I'm just going to mark them as 6 before we start, so I don't have to do that later.
MR. ANGINO: You might want to mark it D-1 because I have been marking them for use at trial. So we would call this as D-1.
MR. WOLGEMUTH: Okay. That's fine.
Copy of packet of documents beginning with Office Note for Vincent Mazzamuto dated 9/18/02 - produced and marked for identification as Exhibit D-1.
MR. WOLGEMUTH: I'm not going to refer to them quite yet.

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THE WITNESS: Okay.
CROSS EXAMINATION
BY MR. WOLGEMUTH:
Q Now, Doctor, you had testified that you are board certified in internal medicine, correct?
A That is correct.
Q Okay. And you agree with me that you are not board certified in psychiatry?
A I am not.
Q Do you even know what the requirements are for board certification in psychiatry?
A I assume it's completing a psychiatric residency, and passing a standardized board examination.
Q Okay. And you agree with me that you are not board certified in orthopedic surgery?
A I am not board certified in orthopedic or neurosurgery for that matter.
Q Okay. And you are not board certified in physiatry?
A I am not.
Q Okay. What is physiatry?
A Physiatry is rehabilitation medicine. Doctors who do -- you know, work at rehabilitation hospitals, work with injured patients, work with

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people post-surgery like the Mechanicsburg South Rehabilitation unit, things such as that matter.
Q Okay. And neurology or a neurosurgeon that would be somebody that operates on the back?
A Neurologists are medical physicians who diagnose neurologic diseases. Neurosurgeons operate on nervous structure, which includes both back and brain.
Q Okay. Now, Doctor, would you agree with me that you are not an expert in orthopedic conditions?
A I am not an expert in all orthopedic conditions, that's correct.
Q And would you also agree with me that you are not an expert in psychiatric conditions?
A I'm not an expert in psychiatric conditions.
Q Now, Doctor, you had previously provided medical records to Mr. Angino in response to a request that he had for Mr. Mazzamuto's records, and I think you even provided us with medical records pursuant to subpoena. Do you recall that?
A I have provided many records. I assume that's correct.
Q And the records that you provided to us

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would have been all the records that you had?
A Correct.
Q And the records that you provided include your progress notes or your office notes?
A That's correct.
Q Doctor, would you agree with me that, as a physician, it's very important to include any significant condition in your office notes?
A Well, it depends on the nature of the visit. You know, when Mr. Mazzamuto comes to see me, he doesn't necessary come to see me on every visit with the, you know, express purpose of talking about his back pain or, you know, there are routine physical examinations, there are, you know, acute illnesses, and not every medical condition of that patient is covered and documented with every exam, no, that's not -- we don't have that much time.
Q Okay. But you would agree with me, Doctor, that if Mr. Mazzamuto came in, and was complaining about back pain, most likely it would have been significant enough that you would have recorded it in that days' office visit notes?
A If that's what we were dealing with, yeah.
Q Or, similarly, if he had come in and complained about some type of anxiety problem or

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depression problem, and discussed it with you, you would have included it in your office notes for that visit?
A I would think so, yeah.
Q And you would agree with me that -- excuse me -- that something that would prevent somebody from working would be a significant condition or something that you most likely would include in your office notes?
A I would include it, but if it's been an ongoing condition for a period of a long time every office visit is not necessarily focused upon his disability or lack of disability. So if it was a brand new issue, we might spend a lot more time with it, but if it's an old thing that really hasn't changed, we might not. You know, again, we have quite tight schedules, and trying to deal with each problem with each visit isn't always possible, and, again, the documentation hopefully addresses the main points of that particular visit, again, primarily for the purpose of, you know, keeping track of his medical conditions and treatment, not necessarily for supporting insurance claims or disability claims.
Q Okay. But if it's something that was

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significant and something that you discussed, most likely it have ended up in your notes?
A It would have been in the notes in some form, sure.
Q All right. And, Doctor, do you agree with me that it's important to include the treatment that you are rendering in your office notes?
A Sure.
Q And do you agree that you include -- or it's important to include the treatment that you are rendering because other physicians might actually be reviewing your notes, and rendering treatment based upon your office notes?
A Sure.
Q And, similarly, you would agree that it's important to include any medications that you are prescribing in your office notes?
A They are in the notes or the medication flow sheet, yeah. They should be there in some form.
Q And, again, that's for your own benefit, and for the benefit of other treating physicians --
A Right.
Q -- who might be using those notes?
Doctor, would you agree that it's

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important to include things like therapy, individual or group therapy, in your notes if Mr. Mazzamuto was receiving it or if you had prescribed it?
A What are you talking psychiatric therapy or what? I'm not sure what therapy you are referring to.
Q Well, it would be a number. Psychiatric therapy, if you had prescribed psychiatric therapy, would you include that fact in your office notes?
A You mean medication?
Q No. In addition to medication. I'm talking about, you know, counseling --
A See a psychiatrist?
Q Seeing a psychiatrist?
A Correct.
Q You would include that in your office notes?
A Yes, I would.
Q Okay. And if you had recommended therapy such as physical therapy -- in fact, I think you do reference physical therapy in your notes frequently?
A Right.
Q And, Doctor, would you agree that if your office notes are incomplete that Mr. Mazzamuto may not get the proper treatment from other physicians?

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A Any physicians I guess who had or were reviewing those notes, correct.
Q And generally, Doctor, would you agree that when Mr. Mazzamuto relays symptoms or gives you information, describes his condition, that you would include that, and you would include it accurately in your notes?
A I would probably make sure it is included accurately, though if it was repetitious from a past visit, I may not reiterate the same facts with every visit in every note.
Q Now, Doctor, do you know what a global assessment of functioning is or a GAF?
A I have heard of it.
Q Do you agree that it's a tool to evaluate and rate a patient's overall psychological functioning?
A Yes.
Q Doctor, do you agree that the GAF scale is a scale from 1 to 100 based upon the individual's psychological, social, and occupational functioning?
A I don't know have knowledge of whether it's a scale from 1 to 10 or 1 to 100. I don't know that.
Q Well, did you agree that such a test as a

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GAF would be helpful in diagnosing and treating a patient with psychiatric conditions?
A I think if you were screening people, and you weren't sure if they were depressed or anxious, it might be another tool you could us.
Q So, Doctor, since you don't really know what a GAF score is or the scale is, you wouldn't really be able to understand what a GAF score of say 31 to 40 would represent?
A Well, I would assume it would be someone who's significantly depressed and nonfunctional. There are many -- there are many depression -- there's a depression index. There are many tools one can use to screen a population for depression if you think the diagnosis is in doubt.
Q Doctor, do you agree with me that nowhere in your office notes do you have a reflected GAF score for Mr. Mazzamuto?
A I certainly agree with that since I don't use it.
Q Now, Doctor, would you agree that certain types of medical tests or procedures or examinations are done to help evaluate a patient's complaints?
A Yes, I agree with that.
Q And do you agree that the medical tests

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are used to find the cause of an individual's problems or complaints?
A I think medical tests are used to diagnose medical complaints when the cause is not evident, sure.
Q And that medical tests are used to help a physician prescribe treatment for someone's complaints?
A In some cases, sure.
Q And sometimes medical tests reveal that there's no problem after all?
A Sometimes they do.
Q And in this -- and, Doctor, sometimes the medical tests reveal that the condition can be treated or even cured?
A Well, I think sometimes medical tests, sure, show that something can be treated. You know, the cure thing is -- I mean, that's really an open question to think about what you talking about. So I will say yes, I agree with the fact that it shows that there may be an alternate treatment.
Q And, Doctor, would you agree that the use -- or without the use of medical tests that you may be left to reply upon or accept the patient's subjective complaints?

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A I think that happens all the time.
Q And in this case you acknowledge that you didn't request a GAF score for Mr. Mazzamuto?
A That is true.
Q Doctor, would you agree that a mental status exam is another tool used to evaluate a patient's overall psychological function?
A It's used to evaluate people mainly when they are having periods of confusion trying to especially rule out things such a dementing process like Alzheimer's disease.
Q And, Doctor, the things that you would look at in a mental status exam, do you agree that one of the things you would access is the person's appearance?
A Yes.
Q Motor behavior?
A Huh uh (yes).
Q Speech?
A Uh huh (yes).
Q Attitude?
A Uh huh (yes).
Q Mood?
A Sure.
Q Affective expression?

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A Yes.
Q Whether they are having hallucinations?
A Correct.
Q Thought processes?
A Uh huh (yes).
Q Extreme of thought?
A Uh huh (yes).
Q Thought content?
A Yes.
Q Whether they have abstract thinking?
A Yep.
Q The ability to concentrate?
A Uh huh (yes).
Q Their orientation?
A Uh huh (yes).
Q Their memory?
A Yep.
Q Their judgment?
A Correct.
Q Their insight?
A Uh huh (yes).
Q And their reliability?
A That's correct.
Q Now, Doctor, would you agree that it would be important to perform a mental status exam before

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treating an individual with a psychiatric condition?
A Not necessarily, no.
Q And why is that?
A Because, again, depending upon what the symptoms are that they are presenting with, you know, whether they come in feeling anxious, if they come in expressing thoughts of fear, sadness. That, again, if they don't come in with complaints or family members of hallucinations or confusion, depression is a very common problem, and again, you get information that you think you need, but you don't have to get every test on every patient just because it's a test that pertains to that particular medical condition. So no, I don't think it's required to do a mini mental status exam or a full mental status exam on every patient that you are going to consider putting on anxiety or antidepressant medications. No.
Q Fair enough, Doctor, but do you agree with me that of those fifteen or twenty items in the mental status exam that maybe four or five of them are appropriate to examine in determining whether somebody is depressed or anxious?
A I think they are important. Again, I think that they can also be obtained at times from

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just interacting with the patient, from having normal conversations with them, and from, you know, sort of having an ongoing relationship with them that some of those information can also be obtained that way as well.
Q And would you agree, Doctor, that some of the things that you might be looking at would be the person's mood?
A Uh huh (yes).
Q And their affective expression?
A Yes.
Q Their motor behavior?
A Well, motor behavior I guess in a way has to do with more of a neurologic assessment, but sure.
Q Their speech?
A More of -- yeah, what their gait, their record of -- excuse me -- their gait -- or their pace of speech, and whether it's fluent or whether it makes any sense at all.
Q And finally their thought content?
A Uh huh (yes).
Q Doctor, do you agree that nowhere in your office notes do you reflect that you performed a mental status examination on Mr. Mazzamuto?

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A I will take your word for it.
Q Doctor, I'm sure you would agree that one way to treat somebody with anxiety and depression is through the use of medications?
A Correct.
Q And another way of treating them or treating somebody with conditions of anxiety and depression might be some type of therapy?
A Could be.
Q Individual therapy, group therapy?
A Correct.
Q And would you agree that the only treatment that you have implemented for Mr. Mazzamuto is a regime of medicines?
A Correct.
Q And would you agree that you have not recommended a psychologist or a psychiatrist?
A I don't think I have recommended a psychologist, no.
Q And I believe that you had stated in your direct testimony, Doctor Bower, that the reason you didn't refer Mr. Mazzamuto to a psychologist or psychiatrist was the lack of availability?
A Well, what I said that was psychiatrists are in short supply. I did not say that

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psychologists or counselors are in short supply.
Q Okay. Doctor, your office is located in the Carlisle area?
A Yes, it is.
Q I'm just going to read a list of individuals, and would you identify if any of these are psychiatrist or whether they are psychologists? Margery Andrews?
A Psychologist.
Q Kay Balsonus?
A I don't know. Psychologist, social worker, counselor or something.
Q Okay. Brenda Barrick?
A Don't know her.
Q Joann Chambers?
A I think psychologist.
Q John Paul Checket?
A I assume a psychologist. I don't think he's a physician.
Q Joann Koslet?
A Some kind of a counselor.
Q Nancy Demuth?
A She's a psychologist.
Q How about Catherine Ellis?
A Don't know her.

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Q Kenneth France?
A Don't know, but not a psychiatrist.
Q Edward Franco?
A Psychologist. Has his own group.
Q Delores Hogg?
A Probably the wife of an attorney. I don't know. Steven Hogg's an attorney. I don't know about Delores.
Q Franco Psychological Associates?
A Well, that's back to Franco. We mentioned him already.
Q How far, Doctor, is Harrisburg from Carlisle?
A My professional medical opinion about eighteen miles.
Q Is that too far to refer one of your patients for psychiatric treatment?
A It's not too far, it's -- but it is a matter of getting there, and it's a matter of, again, availability of openings. You know, because somebody's in the phone book doesn't necessarily mean that they are easily available or seeing new patients.
Q Have you ever examined the availability of psychiatrists in the Harrisburg area?

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A I know there are psychiatrists there, sure.
Q Did any of them come to mind in referring Mr. Mazzamuto?
A I didn't really think to -- I didn't think that I wanted to refer Mr. Mazzamuto to a psychiatrist.
Q And the reason?
A Again, I think he was -- we had him under therapy here. I don't think he wants to go to a psychiatrist. You know, with his cultural background I don't think he was interested in seeing a psychiatrist. Unfortunately mental health issues are often colored by the fact that, you know, people view them differently than other medical issues, and while some people are very comfortable to come here and get treatment, they don't have a desire to go to a psychiatrist or a psychologist.
Q Doctor, do agree with me that you had testified early that you think that Mr. Mazzamuto's level of functioning has plateaued?
A It's -- yeah, I do.
Q And notwithstanding that fact, you still don't want to refer Mr. Mazzamuto to a psychiatrist?
A I could ask him if he wanted to go.

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Q As a physician would you recommend if you thought it was in his best interests to go?
A Well, again, at this point he seems to be doing fairly well in his current situation with regard to his marital -- you know, the marital issues he was having, his anxiety in that now that's he's not at the restaurant on a regular basis. So, no, I mean, again, I don't feel compelled to refer him to a psychiatrist unless he tells me that he's having more distress as it pertains to his anxiety and depression, that if the medications are controlling things, you know, whether sending him to a psychiatrist is going to better that situation at this point I don't know. It doesn't change his back issue, but, you know --
Q Doctor, you had testified earlier that his psychological condition was his major condition at this point?
A That was at this point. That was right after his heart attack. That was back in the year 2000.
Q Okay. Presently what is his major condition?
A His major condition or disabling condition?

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Q Disabling condition.
A His back.
Q Doctor, do you recall when I took your deposition on April 16, 2002?
A I remember you being here. I will take your word for the date.
Q Okay. Do you recall at that time that you were under oath?
A I do recall that.
Q Do you recall it was something similar to this where I had asked questions and you provided answers?
A Very similar to this, correct.
Q And Mr. Mazzamuto's counsel, Mr. Angino, was there?
A He sure was.
Q And you promised to tell the truth, correct?
A I try to.
Q Doctor, I'm going to read a question and your answer. It's on page 59. I just want to be sure that I'm reading this to you correctly.
A Go ahead.
Q On page 59?
A Uh huh (yes).

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Q The question is and if Mr. Mazzamuto identified his work duties as twenty percent bookkeeping, twenty percent office duties, and sixty percent supervising employees, anything in his back condition that would prevent from doing those types of job duties?
Answer: I think he would be uncomfortable again with sitting over a desk with the bookkeeping. You know, what can people do, pain tolerance and things like that are all individual. Again, with his back, if that was his only issue, could he muddle through further, he probably could.
Did I read that right?
A Yes, you did.
MR. ANGINO: And it's referring just to his bookkeeping.
THE WITNESS: Correct.
BY MR. WOLGEMUTH:
Q Doctor, in treating somebody with anxiety or depression, do you agree that an appropriate treatment would be to recommend that that person confront his anxiety, confront the situations that caused the anxiety to help him become less anxious?
A Not necessarily, no. I mean, it depends -- and sometimes anxiety is an internal thing, it's

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a brain chemical thing. You know, I don't think -- are you talking about if they fall of the horse, and they are anxious, so they get on the horse?

MR. ANGINO: I'm going to at this point make an objection, and we will go off the record.

MR. SIMMERS: Off the video record. The time is 4:29 p.m.

(Off the video record.)

MR. ANGINO: I have given great leeway to your asking him questions about seeking a psychiatrist, and seeking various forms of psychiatric type treatment. The case is about whether somebody is disabled or not disabled. We are not here questioning the Doctor's treatment or lack of treatment or referral, we are questioning whether he's disabled. According to Doctor Bower, he is disabled. So I think the relevancy or the likelihood of this leading to any relevant information, even if we were in a deposition, would be highly suspect. The fact that we are actually in a court setting, and we are asking questions of the Doctor, my objection at trial, as it is in this deposition since it's being taken for the forum -- for the purpose of trial -- is that continuing to ask this Doctor questions about why and why he

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didn't refer Mr. Mazzamuto to a psychiatrist, and what would psychiatrist do, and might the psychiatrist be able to help things, that has nothing at all to do with a case where Mr. Mazzamuto is suing his insurance carrier that sold him a policy that said that if he is disabled they were going to pay him, and they haven't paid him.

So you can go back on record.

MR. SIMMERS: I'm back on the video record. The time is 4:31 p.m.

(On the video record.)

BY MR. WOLGEMUTH:

Q Doctor, how do you determine if an individual is disabled from anxiety or depression?

A Well, first, again, let me preference that, again, I'm not a psychiatrist, and so I think that if somebody was unable to undergo the rigors of whatever was required of them in their job, if they were unable to concentrate, focus, recall, retain or perform the function of their job because their anxiety was such that it prevented them from functioning, that would constitute disability. Now, disability is a legal definition, usually not a medical diagnosis, but that's how I would probably -- if the condition leads to an inability to

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perform the tasks that are central to the job, then I would say you are disabled whether it's from anxiety or backs or whatever.

Q Okay. Doctor, I'm going to refer to what I have marked as D-1, which are your office notes. You agree with me, Doctor, that they are your office notes?

A Uh huh (yes). They are from my record, correct.

Q Now, turn to the office notes for August 23, 2000?

A Okay.

Q Do you have them?

A Yes, I do.

Q And do you agree with me, Doctor, that nowhere in your office notes do you include any assessment of Mr. Mazzamuto's mood?

A It says he is more emotionally labile. I don't know if that plot plays into mood per se. That's a reflection of his mental state or whatever you want to call it, mood or affect or whatever. It's kind of a global -- a global assessment.

Q Okay. And do you agree that there's nothing in your notes for that day that reflect your assessment of his motor behavior?

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A Yeah, I don't think that has any bearing on anything at that point.

Q Now do you refer to his speech or his thought content?

A No. Again, that's normally something one does when somebody is delirious or demented or having, you know -- again, that would be for different sorts of mental disorders, not for somebody who's anxious or depressed.

Q Okay. Now, Doctor, I believe that you do identify that Mr. Mazzamuto suffered from anxiety symptoms?

A Uh huh (yes).

Q But you agree that you don't specifically identify what those symptoms were?

A Correct.

Q And, in fact, your notes don't reflect whether those symptoms were present while he was in your office, do they?

A They do not.

Q And do you agree, Doctor, that your office notes don't reflect what specific duties or activities were causing Mr. Mazzamuto's anxiety?

A No, they do not reflect what duties were causing his anxiety, they just reflected that he was

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anxious after his recent hospitalization for a heart attack.
Q Okay. Now, Doctor, I would like you to turn to your office notes for November 29 of 2000. Find them?
A November 19. Got it.
Q And, Doctor, am I correct that at that time you indicated that Mr. Mazzamuto's chronic low back pain was stable?
A Let's see. It says chronic low back pain controlled on Neurontin.
Q Well controlled on Neurontin?
A Correct.
Q And I believe you state that at that time his anxiety was doing well on Wellbutrin?
A It was doing well, correct.
Q All right. Doctor, let's move on to your office notes of August 11 of 2001. Find that?
A Uh huh (yes).
Q Do you agree with me, Doctor, at that time you diagnosed or your impression was that his chronic anxiety was stable?
A Correct.
Q And would you agree that your definition of stable or your use of the world stable means at

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that time he was no -- that he was not expressing current symptoms of anxiety?
A It did not seem to be interfering with him at that point.
Q Doctor, do you agree with me that your notes don't reflect any type of specific work restrictions?
A They don't. Again, he's self-employed, so I don't really necessary give notes or give work restrictions to people who are in charge of their own business. I'm not even sure he was working at that point to tell you the truth. That was in his -- after his myocardial infarction, and he was undergoing cardiac rehab. Whether he was at the restaurant on a fulltime basis at that point I don't know, but I don't think he was.
Q Okay. Doctor, let's move on to your March 12, 2001 notes?
A Okay.
Q And, once again, Doctor, would you agree that your notes don't reflect any assessment of his mood or affective expression?
A Right. Because he came in with numb legs, and that's what we were focusing on on that visit.
Q So your notes that reflect any type of

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symptom that you would assess in terms of any type of anxiety or depression on that specific day?
A Right. Again, yeah, I think the focus on that visit was primarily because of the numbness in his leg. It does note that he was having chest pain, and, again, I think there was a thought that, again, since his heart had been re-tested and it was normal, that, in fact, the chest pain might be a symptom of anxiety. He was actually re-hospitalized soon after he was out of the hospital for what turned out to be not heart pain, and, again, chest pain is a common symptom of anxiety as well. But I think this visit was primarily regarding -- again, the major focus of the visit was about the numbness in his legs.
Q Okay. Then, Doctor, on page -- that page 25 is that a continuation of your March 12 visit?
A I don't think so. No, that's -- oh, 25. Yeah, 25 to 24 that's all one note.
Q Okay. So the impression on page 24, I believe No. 3 ongoing stress and chronic anxiety?
A Uh huh (yes).
Q So you apparently you did mention his chronic stress at that point?
A Well, again, if you -- the second

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paragraph in the note on page 24 said he had an episode where he became very upset at an insurance agent, felt some chest pain, took two or three nitros, felt like he was going to break out in a cold sweat, and, again, having recently undergone cardiac evaluation, which didn't show any further blocked arteries in his heart, I was taking that as a sign of perhaps his stress and anxiety, that he was getting chest pain, again, from emotional upset.
Q Okay. So this office visit just involved the numbness to the lower leg?
A That was the -- that was the initial reason. It doesn't just involve it, it was the major focus. No office visit in internal medicine or primary care ever deals with just one primary thing, there's always an, oh, by the way.
Q And once again, Doctor, for March -- the March 12, 01 office notes, you, again, don't reflect any type of work restrictions for Mr. Mazzamuto?
A I do not for the same reason I said previously, he's self-employed.
Q Doctor, let's move on to the June 19, 2001 notes. Do you agree with me, Doctor, that your notes reflect at that time, which is the middle -- in June of 2001, that his chronic anxiety was fairly

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well controlled?
A That's what it says.
Q Would that mean that at that point then you didn't make the assessment of his mood or his motor behavior or his speech because it was well controlled?
A Probably because of just his mood and his general -- his general affect, which is, again, his personality. Again, the motor behavior and speech things I think you can leave out because that's generally not a big issue for my concern here.
Q And, again, Doctor, I know you have answer the same question, but that office note doesn't reflect any type of work restrictions for the same reasons?
A For the same reason, that because he is his own employ -- he's his own boss, he has the ability to not do things if he knows they are bothering him. If you work for somebody else, you don't have that ability without getting into trouble.
Q And as -- the fact that Mr. Mazzamuto is self-employed, would you then really have to rely upon him telling you whether he's able to performed these duties in assessing his ability to

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do that?
A Not really, no. All I'm saying is that he does not have an external authority figure hanging over him that will reprimand him if he starts doing something that hurts and he stops because he's his own boss.
I think when it comes to chronic pain, and when it comes to back pain, to a great degree you are always dependent on the person to tell you because there is no lab test for pain, there is no x-ray test for pain. You can document lack of nerve function, but there's absolutely nothing you can do to objectively test for pain. Pain is a subjective symptom. It's becoming very popular in medicine now. It's now the fifth vital sign.
Now -- or every person who has any kind of discomfort, again, back to your scale before, you know, we are supposed to now be doing a 1 to 10 pain scale. That's now, that's not then, but, again, it's a totally objective phenomenon. So, yeah, when I say see these people here, I'm trying to make them better. I'm not seeing them for the purpose of, gee, what if at some point they are suing somebody or they are being sued, how can I best document their complaints today to make it look good later on

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when the lawyers get a hold of the records. Again, there was a time when medical records were for medical issues, now are just legal documents, but I go on too long.
Q Again, Doctor, the point I was trying to make, the fact that you don't include work restrictions for someone like Mr. Mazzamuto is really up to Mr. Mazzamuto whether or not he can perform these job duties, do you agree with that?
A Sure. I do agree.
Q Doctor, in July 9 of 2001 -- do you have your office notes there in front of you?
A I do.
Q Okay. And do you agree with me that at that point -- I'm sorry, Doctor. I want you to refer to your August 20, 2001?
A August 6 or August 31?
Q I might have a --
A There's a 6th on that page.
Q Yeah. Just bear with me a second.
No. Tell you what, let's move on to your December 19, 01.
A Okay.
Q Do you agree with me that at that time you found his depression and anxiety to be borderline

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compensated?
A Yeah, that's what I wrote.
Q What exactly does that mean, Doctor?
A Well,, he was getting by, but he was still having symptoms. He was having -- again, he was somewhat anxious, but he wasn't having, you know, terrible problems at that point.
Q And you were medicating him at that time?
A I would have to look back at my medicine flow sheets to tell you that, but I'm sure he was still on something at that point. I can tell you that in a minute.
In December of 01 he was still on Ativan, he had just stopped Celexa, and we had not yet started Effexor. So that's -- wait a second. Oh, he was still on Celexa. So, yes, he was still on an anxiety depressant medicine, Celexa, and he was taking Ativan as needed at that point. So, yes, he was being medicated at that point.
Q And what is Ativan, Doctor?
A Ativan is a benzodiazepin antianxiety medicine similar to Valium. It gives fairly prompt relief from anxiety, but it's fair short acting. So it's used for sporadic control of anxiety symptoms, but it's not something that, you know, you would

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have to take it multiple times a day for it to last all day long. It's almost for breakthrough symptoms you could say.
Q Okay. And, Doctor, at the end of your first paragraph in the December 19, 2001 notes you state that his mental state is stable?
A I guess -- yes, that's what I wrote.
Q And would that be referring, again, to his anxiety and depression issues?
A Anxiety and depression.
Q Now, Doctor, in your notes of February 14, 2002 you again diagnose -- I'm sorry. Do you have it?
A It have it now, yep.
Q You again diagnosis severe anxiety and resultant depression?
A Uh huh (yes).
Q And, again, Doctor, do you agree that your office notes don't reflect any type of assessment of his mood, expression, behavior, speech or thought content?
A That's true. I just wrote that he came in for ongoing evaluation of his anxiety symptoms, although I did not list them.
Q And, Doctor, would that also be true for

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your office notes of March 14, 2002?
A That's true, other than saying that he just does poorly, and that he's smoking more, and more uncomfortable, but I did not comment on any other specific symptoms.
Q Now, Doctor, under your No. 1, under impression, I believe you state that the severe anxiety and depression now becoming his biggest problem?
A As of that visit, sure.
Q You mean that that problem was bigger than his back problem? Is that what you meant by that?
A I think at the point of that visit, correct. From his -- the symptoms he was having, difficulty sleeping problems, you know, in that regard I think as of that visit. I felt for that visit it was his biggest problem, sure.
Q Doctor, I want to refer you to your -- I think it's your April 22, 2002?
A Okay.
Q And, once again, I believe you identified under impression as severe anxiety and depression?
A Uh huh (yes).
Q And, again, do you agree that you didn't make any specific assessment of those five factors

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that I have been discussing with you?
A I sure do.
Q Doctor, you said there was a skin rash. Was that a side effect of a medication?
A I don't know. I said it is possibly from the Effexor, but it wasn't there at that time, and it's always hard to diagnose a skin rash that's no longer there.
Q And, Doctor, your notes reflect at that time that his back was at baseline?
A Right.
Q What does that mean?
A It means it's the same as it was before.
Q Not getting any worse?
A Well, didn't comment that it was getting worth. It was no better than previous evaluations.
Q Doctor, I would like to direct your attention to your office notes of May 29, 2002. Under your impression, do you agree that you reported that his chronic anxiety was improved, but still not resolved?
A Correct.
Q And you also reported no current symptoms of ischemia?
A Correct. That means that he's not having

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chest pain referable to blocked arteries in his heart.
Q Doctor, Mr. Mazzamuto apparently referred to a niece or a nephew that had some type of medical condition. Did he ever express that that itself was causing him any type of anxiety or depression?
A He did. In fact, the previous note, December 13 of 02 dealt with that. He had a niece who had developed a brain tumor, and was undergoing therapy at that point.
Q Okay. The stressor anxiety that was related to that issue, that's something that just arose recently, that's something that wasn't occurring for the past year or years?
A No. That was -- I mean, again, I think that I might have heard about it slightly before that visit, but that was new I believe as of that visit. That has not been one of his ongoing problems, that's a relatively recent event in the last year.
Q Doctor, let's move on to your August 2, 2002 notes. At that time you reported that his coronary disease we had no current symptoms?
A Correct.
Q And that pretty much confirms what

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testimony you had on direct examination by Mr. Angino?
A Correct.
Q And do you agree that you reported his chronic anxiety was stable on his current medicine?
A Correct.
Q And, once again, Doctor, there's no discussion about any type of work restrictions in that office note for the reasons you previously identified?
A Correct.
Q Okay. Doctor, let's move on to the office notes of September 18, 2002. Do you agree with me that in September you reported that his chronic anxiety was seemingly better or under better control today?
A That's what I said, correct.
Q Doctor, you also reported that there was a noninvasive study of his lower extremity, and found them to be normal?
A We were looking at the circulation to his lower extremity, seeing if they were getting adequate blood flow. If you have blocked arteries to you leg arteries, and you are walking, that can be a reason do get lower extremity pain. So we sent

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him to a vascular surgeon to make sure that some of his leg discomfort was not coming from poor blood supply. He did the studies, he said the blood supply is normal.
Q Okay. Now, I believe you had testified on direct, Doctor, that you believe that Mr. Mazzamuto had an impingement from stenosis?
A Again, based on his MRI findings, the symptoms he describes, and, again, he was evaluated fairly -- fairly completely by an orthopedic surgeon, specialist, board certified in back surgery, Doctor Gelb, who was previously at Hershey, who, in fact, thought his symptoms all came from his back, and recommended that he thought that surgery might be an option for him if Mr. Mazzamuto was willing to undergo that. Of course, he gave him no guarantees, and said there's lots of potential problems, but Doctor Gelb seemed to be quite satisfied that his back was a big problem, and thought that it was causing his symptoms, and again, you know, part of these notes here where not everything is covered with every visit, you know, that was going on in the background. He was seeing Doctor Gelb in 2000 and 2001 before Gelb left for Baltimore, and you are right, and I sort of accept

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the opinion of the specialist in that area that it's a big problem for him. So, yeah, I don't necessary do everything for his back every time he comes in. He's been seen by a back specialist who says, yeah, you got a back problem, and I can operate on you if you want.
Q Okay. And do you agree, Doctor, that at one point he had an EMG done?
A He did have an EMG done, and it was normal.
Q And what does that reflect, Doctor?
A It means that there was no sign on that test that the peripheral nerves in his legs were being pinched.
Q Okay. In fact, did you see any tests at all that suggest that his nerves were being impinged or pinched?
A Again, the MRI as long as ago 1996 which says the spine is being pinched. It says, you know -- and so yeah. Again, not -- tests don't always all agree with each other, so you have to take the whole clinical scenario. So, again, you know, it says the stenosis -- you know, that it impinges, and it actually pinches off so that there's no flow of cerebral spinal fluid in the area. So, again, we

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have got symptoms that go along with a problem from the spinal stenosis, we got a back specialist at Hershey who tells me, yeah, this guy's got a back problem, I have an EMG that says no, these nerves here are not being pinched, but --
Q Okay. And that EMG was done more recently than the 1996 MRI, do you agree?
A I agree.
Q Doctor, I want to direct your attention to -- let me see if I can find this. Just bear with me a second.
Okay. Your May 29, 1996 office notes?
A Okay.
Q I think you report there at the end of your first paragraph that he has had several falls, recently slipping out a chair, which seems to have aggravated the problem?
A Uh huh (yes). That's correct.
Q In your office note of April 3, 1996, I believe you report that he had fallen in January, and then fell again last week hurting his back?
A Correct. That's why on the initial insurance forms when it says when did this begin, I couldn't be specific, and I sort of wrote both January and April because, again, there seemed to be

two events that kind of triggered that most recent -- or that particular flare up.
Q Okay. And, Doctor, you are aware, aren't you, that Mr. Mazzamuto claimed that he hurt his back in July of 2000 while riding in the ambulance to the hospital from the day he had his heart attack?
A I'm sure, again, maybe he aggravated it then. Again, I don't -- I think his back problem long predates that, but, again, you know, chronic back problems can be flared up by injuries, falls, twists, you know, bad body positioning, things like that. So that I didn't know that he was claiming that the ambulance ride had anything to do with it, but, again, lots of things -- you know, lying on a catheterization table can be a very uncomfortable thing for somebody with a chronic back condition, but I think it's clear that his back problem dates back, again, in the previous notes, as far back as 1992.
Q Okay. And do you agree with me, Doctor, that slipping and falling on the ice, and falling out of a chair are more of a significant trauma than receiving a bump in a ambulance ride?
A I would agree that falling on the ice is

probably the most significant of those things. Again, I don't know what the bump in the ambulance was. We live in Pennsylvania, there's lots of potholes. I will refer judgment on that one.
Q Now, Doctor, I believe you had testified some of the work restrictions when Mr. Angino was asking you, that he shouldn't lift more than twenty pounds? Does that sound about right?
A Yeah.
Q Did Mr. Angino ever tell you exactly what he had to lift while he was working?
A Did he tell me, no. I was -- I have been in the restaurant, I have seen the video of the restaurant that Mr. Angino provided for me.
Q So you agree that Mr. Mazzamuto never specifically told you what -- that he had to lift heavy things at work?
A He did not tell me in my office that he had to lift heavy things at work.
Q You are claiming that you saw him lifting heavy things?
A I'm claiming that I saw heavy things in the restaurant that go along with work in the restaurant, and I'm not claiming to be an expert on restaurants, but, again, he tells me he can't do the

things at work, he did not specifically tell me that he can't lift twenty pounds, that he can't lift a particular thing. Again, I think that his back is a problem, and I know that there are twenty pounds items at his place of business. There are cases of cheese, there are big vats of pizza dough, there are big jars of -- of, you know, peppers. So, again, you know, could he lift something twenty pounds, he sure could. Can he do it over and over again, can he do it repetitively, you know, can he do it day in and day out, no, I don't think he can.
Q He can do it occasionally though, lift up to twenty pounds, can't he?
A Yeah. Anybody can do anything occasionally, but that's not the same as, you know, doing your job.
Q And do you agree with me, Doctor Bower, that Mr. Mazzamuto told you that he would have to sit down and stand up in order to accommodate the pain that he had?
A Sit down, stand up, and occasionally lay down. It's kind of a continual shifting of positions.
Q Now, Doctor, would you turn to your office notes for 10/23/96?

A Okay.
Q Okay. At that time I believe you reported that Mr. Mazzamuto still had intermittent -- I'm sorry -- intermittent numbness in his both legs?
A Uh huh (yes).
Q And he still has low back pain, which is improved?
A Correct.
Q And that he can basically work for about one to two hours during the day. He's at the restaurant much longer than that, but he's normally seated, and not participating actively in the physical labor?
A At that point that was true because he couldn't.
Q Okay. And that's what Mr. Mazza -- I'm sorry -- Mazzamuto told you back in October of 1996?
A That's truth.
Q In fact, October 23, 1996?
A Right. Another interesting thing from that date is that his weight was 186 pounds then too, and it's now 222 pounds. So things have changed since 96.
Q Okay. Doctor, you agree with me the fact that you recorded that he was working one to two

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hours a day, but basically at the restaurant much longer than that, but he was normally seated, and participating actively in the physical labor indicates to you that Mr. Mazzamuto was working prior to that time, prior to October 23, 1996?

A He was at the restaurant. Again, because he is not subject to -- that he's not subject to an employer's whim as to what constitutes work, he owns the place, so sure, he goes in. Now, what day -- is he working, you know, is he just wanting to make sure things are going well? I mean, that's -- again, it's a much fuzzier area in my mind.

Again, I'm not an employment labor law specialist, but the fact that it's his own business I think blurs the lines between when are you working, when are you there. You know, what -- it's not the same as being employed by somebody elsewhere where, when you are at the job, you are expected to do something now, now, now, now, and so, again, had he been at the restaurant during that time, yeah, I'm sure he was. He owns it. His family owns it. His wife's there. His kids are there. But is he working? I mean, he putters -- I mean, I don't know. I don't know what means.

Q Well, let's just go back to your notes.

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You basically said -- you say can basically work for about one to two hours during the day. That means --

A Right, that's what he told me.

Q He was telling you he was working at least one to two hours?

A He was doing some stuff one to two hours a day.

Q But he was there a lot longer than that, but just sitting down, and not really participating actively in the physical labor?

A Correct.

Q That's what it says?

A That's what it says.

Q Now, Doctor, I want to refer you to Plaintiff's Exhibit 3. It's a document that Mr. Angino had previously given you. Do you have that handy?

A Sure.

Q That's the Attending Physician's Statement?

A Dated which date?

Q 10/23/96?

A Uh huh (yes).

Q Okay. Now, just so we are not confusing

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anybody, the date on P-3, 10/23/96, is that same date --

A It is.

Q -- on the office note of 10 23/96?

A Right.

Q Do you agree?

A Uh huh (yes).

Q Okay. And on No. 13 you had indicated that Mr. Mazzamuto was disabled from April 13, 1996 through October 23, 1996, which is the same day as the office note?

A The day that I saw him, correct.

Q So clearly, Doctor Bower, the statement that you made on the Attending Physician's Statement dated October 23, 1996, couldn't have been correct?

MR. ANGINO: Objection.

MR. SIMMERS: Off the video record. The time 5:04 p.m.

(Off the video record.)

MR. ANGINO: He just told you he only could work one or two hours a day. Disability means you can't work your job regular hours. I mean, how can you say to him that, you know, they are inconsistent. That's my objection.

Back on the record.

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MR. SIMMERS: Back on the video record. The time is 5:04 p.m.

(On the video record.)

THE WITNESS: Well, again, I think he was disabled up until that point. I saw him that day. Whether he was at his restaurant for a couple of hours or doing things for a couple of hours, again, I don't think that constitutes, you know, being not disabled. That's -- I mean, he's puttering around, he's doing a few things, but he wasn't clearly doing his normal activities. He wasn't doing his normal job. So I don't think that's inconsistent.

BY MR. WOLGEMUTH:

Q You agree with me, Doctor, that that No. 13 doesn't say dates of continuous personal disability?

A Well, I guess it doesn't, no.

Q In your own mind you know the difference between personal disability and total disability?

A I would assume a total disability you can't do anything.

Q Okay. And per Mr. Mazzamuto's discussion with you on the same day, October 23, 1996 --

MR. ANGINO: I'm going to have to go off the record again.

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MR. SIMMERS: Off the video record. The time is 5:05 p.m.
(Off the video record.)
MR. ANGINO: The Supreme Court has said that the fact that you can go into your office and do some work for a couple of hours a day does not mean you are partially disabled, it means you are totally disabled. Partial disability has to mean that you work an eight-hour day, and you could only do part of your work. So when you are asking the Doctor questions that have to do with the law, you know what the Supreme Court has said with regard to that. So I'm going to object to a question being asked to a Doctor about a legal issue that you darn well know the answer, and it doesn't have anything to do with that.
MR. WOLGEMUTH: Okay. Well, I would like to respond to that objection. The only relevant issues here are what the contractual language between a policy that Mr. Mazzamuto had and the language contained therein. So regardless of what Supreme Court decision you are referring to, I can ask these question, and I intend to, and I will ask the questions.
MR. ANGINO: And I can continue to object

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to them --
MR. WOLGEMUTH: Yes, you can.
MR. ANGINO: -- on that basis that basically total disability means under the law, as I understand the law, to mean that you cannot do your job as you did it before. Partially disability means you can go and do eight hours, forty hours a week, but there's certain parts of your job you can't do. So we can -- this is all a matter of record.
MR. WOLGEMUTH: Let's go back on the record.
MR. SIMMERS: Back on the video record. The time is 5:06 p.m.
(On the video record.)
BY MR. WOLGEMUTH:
Q Doctor, referring again to P-3, Item No. 14, which states dates of partial disability, you put a zero or slash through that?
A Right.
Q Okay. So in your view Mr. Mazzamuto was totally disabled from 4/13/96 through 10/23/96?
A In my opinion, sure.
Q And he wasn't partially disabled?
A Not in my way of viewing partial

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disability in Mr. Mazzamuto's employment situation, no.
Q Okay. At the very least, Doctor, you agree with me that he could perform some of his job duties as of October 23, 1996?
A He could do some of his job duties for a short period of time.
Q Now, Doctor, Mr. Mazzamuto's anxiety and depression, is that preventing him from doing his job duties like bookkeeping?
A At some points it seemed that it did. Whether it's -- you know, again, I don't know that right off about -- right for this moment, but, again, there were some points when he was telling me he was too aggravated, he was too -- he would get upset about everything, he couldn't concentrate, and, again, and part of it was also that he just couldn't sit for long enough. But at various points during this whole saga there had been times when his anxiety has prevented him from being able to concentrate. He couldn't focus.
Again, it's a fluxing state as you can tell by all the notes we have been going through that, you know, things worsen a little bit, they get better a little bit, they worsen a little bit.

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There's a constant ebb and flow to this, it's not a static situation.
Q And you agree that at least it's my understanding that his anxiety was -- and depression was prohibiting him from being able to do like his office duties, duties like as calling a food supplier, checking prices, talking to service people, talking to customers?
A Correct, that was my understanding.
Q And, again, just so I understand, and what you are telling the jury is the reason he can't do these type of job duties is because he might fly off the handle in a rage or something to that effect?
A At that point in the past there was that possibility. I think at this point he's doing better in that regard. You know, that -- I don't -- I think some of these anxiety issues have improved, and, again, at some points the anxiety was his biggest problem, at some points the back was his biggest problem. When he was having a heart attack, at that point it was his biggest problem. But the relative importance of these things, again, has fluxed.
Now, could he call a food supplier tomorrow, and at that occasion do well in a limited

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-- he probably could. Can he do it day in and day out, again, back -- you know, part of the reason that his stress levels are better now, and that he's doing better from his anxiety is he's not in the restaurant.

At least that's my understanding of why he's doing somewhat better, is that his family has basically sent him home, and said, you know, stay out of here, we don't want you getting upset. We don't -- they are afraid that if he gets upset, his blood pressure will go up, he will have a heart attack, and I don't think that's a likely scenario, but, again, they certainly see that he does get upset if things aren't going well at the restaurant especially because physically then, when the back comes into it, he can't intervene, and just do it himself.

Q And, again, your opinion, the reason he can't do these I will call them administrative type duties is because of problems like the focusing, and concentrating, and the inability to focus and concentrate?

A I think at some points it could be focus and concentrating. At some points it could be because his back just doesn't allow him to sit and

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stand over the paperwork for a long periods of time, and, again, a lot of this takes place in the restaurant, where, again, he's sort of immersed in the whole milieu of all the other stuff that's going on, which comes to, again, re-aggravating the anxiety issues because, when things are going poorly or something is not right in the restaurant, he's been having trouble dealing with that because, again -- my understanding -- this is not -- you know, of just knowing him, as a small business owner -- I mean, I think small business owners, you know, have their fingers enmeshed with their business, and, you know, if you can't jump in and do things, it's a very frustrating scenario.

Again, could he do booking occasionally, again, I'm sure he has good days and bad days as we all do. I don't know whether he could sit at his desk and do his bookkeeping everyday at the restaurant, and call suppliers everyday at the restaurant and perform adequately, I don't know.

Q Doctor, do you agree with me that on those notes that -- the office notes that I have identified as D-1, which I think are all -- most of your current notes through the end of 2002, that you have nothing -- or that you don't indicate anywhere

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in there that Mr. Mazzamuto was actually having problems coordinating things at work or focusing things at work?

A I'm not sure if that's ever not documented in there or not. I have had discussions with his wife. On other occasions, again, not as part of one of his office visits, so it weren't show up on the record, but, again, I guess I -- you know, I don't know whether I specifically mentioned that or not because, again, the focus of my visits here were basically trying to take care of Mr. Mazzamuto.

It was only after the fact, when asked to fill out a form that says what can he do and what can't he do, which is really not my concern when I'm seeing him in the office, is to then try to go back and figure out based upon what I know about him medically and mentally, and come up with an assessment, get those work restrictions you keep asking about because, again, in my day-to-day practice with Mr. Mazzamuto we don't spent a lot of time with me telling him you can't lift things, you -- you know, you can't be in a stressful situation, you can't do those things, again, because he has -- my understanding is he has the ability to not do those things if he doesn't -- you know, if he

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doesn't have to. There's somebody compelling him to do those things.

So, again, when I fill out a form like this, it's in some ways an artificial situation where I now have to go back, look at my notes, look at what I know about Mr. Mazzamuto, and then try to put into plain language for an insurance company or for disability or whatever what I believe to be the limits of his disabilities, what I believe to be his impairments, not that I necessarily felt the need to spat all that in my medical record because in my doctor-patient interaction with him that wasn't really relevant at that point.

In 1996 when I'm seeing Mr. Mazzamuto for his back, for his anxiety after his heart attract, my focus is not based upon how can I best document here his mental status exam so that at some point somebody questions whether or not he truly has anxiety, it will be well documented in the record. I was just trying to take care of his anxiety, his depression. These forms from the insurance company isn't -- is an attempt to basically quantify as best I can what I know about him, and in part upon them what I think reasonable restrictions would be, but they don't show up in the records because at the

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point of the records being made they really weren't relevant to his medical care.
Q But you agree with me, Doctor Bower, that, if Mr. Mazzamuto was telling you, Doc, I'm having problems concentrating at work, I fly off in a rage, I --
MR. ANGINO: Objection.
MR. SIMMERS: Off the video record. The time is 5:14 p.m.
(Off the video record.)
MR. ANGINO: You know he hasn't worked since the year 2000. How in the world are you asking him questions that he's going to say was he flying off the -- you know, this -- how can you press --
MR. WOLGEMUTH: Mr. Angino, Doctor Bower is testifying that part of Mr. Mazzamuto's disability is his psychiatric condition, which prevents him doing administrative duties, his other type of duties.
MR. ANGINO: Right, but your question to him was is he telling you that he can't do it at work if he's not at work. I mean, the question I have to say is such that you are implying to this Doctor that Mr. Mazzamuto has been in some way

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working at all since the year 2000, and as he is working since 2000 he is experiencing things as he tries to work with figures, as he tries to do the job when you took his deposition, you know he hasn't worked since the year 2000. So that's my objection.
MR. WOLGEMUTH: Okay. I will rephrase the question.
MR. SIMMERS: We are back on the video record. The time is 5:16 p.m., and we are now on tape 2.
(On the video record.)
MR. WOLGEMUTH: I will rephrase my question, Doctor Bower.
BY MR. WOLGEMUTH:
Q Prior to July of 2000 do you agree with me that your office notes don't reflect any type of indication that Mr. Mazzamuto was having problems with concentration at work, with using the ability to focus at work, with being overwhelmed by the details at work, problems supervising employees because of anxiety or depression?
MR. ANGINO: Prior to when?
MR. WOLGEMUTH: July of 2000.
MR. ANGINO: I will have to -- again, I

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object, and go off the record.
MR. SIMMERS: Off the video record. The time is 5:17 p.m.
(Off the video record.)
MR. ANGINO: Prior to July of 2000 he didn't have his heart attack. Prior to July of 2000 I don't know that his records have anything to do with emotionalism, so--
MR. WOLGEMUTH: When did he have his heart attack?
MR. ANGINO: In July 22 of 2000.
MR. WOLGEMUTH: He hasn't worked since July of 2000, correct?
MR. ANGINO: Pardon me?
MR. WOLGEMUTH: He hasn't worked since --
MR. ANGINO: And he hasn't worked since then. So you are saying prior to July, how can he have emotional problems -- okay.
MR. WOLGEMUTH: That's my question.
MR. SIMMERS: We are back on the video record. The time is 5:17 p.m.
(On the video record.)
THE WITNESS: Prior to July of 2000 my records do not indicate that he emotional problems which kept him from doing administrative tasks.

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MR. WOLGEMUTH: Thank you.
BY MR. WOLGEMUTH:
Q Now, Doctor, are you aware that Mr. Mazzamuto has described his responsibilities that he performed at the restaurant to include only executive and office duties?
MR. ANGINO: I'm going to object again. Off the record.
MR. SIMMERS: Off the video record. The time is 5:18 p.m.
(Off the video record.)
MR. ANGINO: You have constantly referred to his application when he applied for insurance back in 1992, and a particular form that he filled out at one time. You know darn well that he supplied you with a statement he says I have to stand virtually all the time. So to ask this Doctor if he knows of something, how could he possibly know what you have in your records, which is in his application, and which is a form that he filled out? So I strongly object to your using such a question to this Doctor as to something that he wouldn't know.
MR. SIMMERS: Back on the video record. The time is 5:19 p.m.

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(On the video record.)
THE WITNESS: No.
BY MR. WOLGEMUTH:
Q You are not aware of that?
A I'm not aware of that.
Q Okay. And if the records reflected that in this case, Doctor, would it surprise you?
A I would think so, sure, especially seeing him at the restaurant in years gone by.
Q And, Doctor, would -- were you aware that the plan described his duties to include managing employees, preparing work schedules, book work, interaction with food companies, administration and office duties?
A That wouldn't surprise me if they were included.
Q Doctor, were you aware that Mr. Mazzamuto described his duties to include fifty percent supervising, twenty-five percent bookkeeping, twenty-five percent other duties, occasionally lifting five pounds, sitting and standing three and a half hours, walking for an hour?
A That would surprise me, sure.
Q That would surprise you?
A That would surprise me.

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Q Now, Doctor, I'm going to read some questions and answers from Mr. Mazzamuto's deposition that was taken on May 10, 2002.
Question: It looks like you did close to $6 million in actual transactions, buying and selling?
MR. ANGINO: Objection.
MR. SIMMERS: Off the video record. The time is 5:20 p.m.
(Off the video record.)
MR. ANGINO: Where he's going on this is that --
MR. WOLGEMUTH: Is this an objection or are you coaching the witness to --
MR. ANGINO: No, no.
MR. WOLGEMUTH: -- respond to a specific question?
MR. ANGINO: No. I'm objecting on the grounds --
MR. WOLGEMUTH: Let's hear your objection then.
MR. ANGINO: The basis of my objection is the relevancy of asking the Doctor for an opinion with regard to his stock investments. I don't think it's within his area to answer questions.

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MR. WOLGEMUTH: Okay. We have it.
MR. SIMMERS: Back on the video record. The time is 5:21 p.m.
(On the video record.)
BY MR. WOLGEMUTH:
Q I'm reading from page 51 of Mr. Mazzamuto's deposition.
The question is it looks like you did close to six million in actual transaction as buying and selling?
Answer: Well, that is the in and out, yes.
I would like to read from page 49 of his deposition.
Question: Were you making your own investment buying and selling decisions in 2000?
Answer: Yes.
Mr. Mazzamuto -- the next question:
Mr. Mazzamuto would it be fair to say that in the year 2000 with all these stock transactions that you were following the stock market fairly closely at least on CNN?
Answer: Yes.
Now, Doctor, Mr. Mazzamuto was asked if the things I just discussed with you caused any

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anger and anxiety. His answer was no.
Now, my question to you, Doctor, is do you agree with me that Mr. Mazzamuto's ability to be a stock trader, to make investment decisions himself, to lose over $300,000 trading stocks, to invest it and brought over $6 million in stocks in one year would be inconsistent with his alleged inability to perform his supervisory and other office duties due to his anxiety and depression?
MR. ANGINO: I have to object again, but I don't need to go off the record. It's -- all of the things that you have been asking him is subject to my first objection. Go ahead.
THE WITNESS: Well, I guess it depends upon when during the year 2000 this all happened, you know, how much of it was pre-heart attack, and how much post-heart attack. You know, again, I think that it -- if he did successfully -- now, if he lost $300,000, maybe he wasn't do so well. I don't know. I mean, I think if he was a wheeler dealer, and closing business deals, you know, yes, that would go against some of the other things we had talked about all together, but the year 2000 includes seven months before his heart attack and five months after his heart attack, and I don't have

the specifics, and maybe you don't either, as to when that all happened, were most of those trades before, were most of them after, I don't know. So, again --

BY MR. WOLGEMUTH:

Q Well, Doctor, I believe the records will reflect that the transaction occurred during the entire year of 2000 and into 2001. And my question is do you agree that engaging in that type of activity's inconsistent with his complaints of anxiety and lack of focus and concentration doing simple administrative tasks?

A It could be inconsistent if it was a persistent pattern, sure.

Q And, again, Doctor, Mr. Mazzamuto testified that doing those activities didn't make his anxious or didn't make him angry. Is that consistent with somebody that is anxious, and somebody that is suffering from depression?

A I don't think it's consistent, but I think it also flies against what has been told to me by his wife, and other, you know, things that have happened at the restaurant, and whether his story, you know, again -- again, it is inconsistent.

Q Doctor, I believe that your office notes

had reflected that Mr. Mazzamuto's psychiatric condition actually became worse during the course of 2001? Do you agree with that statement?

A I do.

Q Okay. And, again, do you agree with me that at that time -- at that time you didn't refer him to a psychiatrist or psychologist?

A I agree with that one hundred percent.

Copy of letter dated April 16, 2002 from Ms. Trudy McGraw, The Wellington, from Douglas J. Bower, M.D. - produced and marked for identification as

Exhibit No. D-2.

Q Doctor, I want to show you what I have marked as D-2, and this letter has been previously identified, but since I have them connected, I will just give you both of them.

Doctor, this report that was dated April 16, 2002, it was addressed to Trudy McGraw. Do you know who that person was or is?

A I do not recall. We get so many requests from so much information from so many different people. I cannot -- my recollection is that she was a nurse, but working for either a legal firm or a insurance firm or some -- but I -- at this point I can't tell you who she is.

Q Was it possible that this letter was drafted and in effort to Mr. Mazzamuto's Social Security application? Would that ring a bell?

A Yeah, that sounds right. When he was -- well, it might have been another legal person who was working for Social Security --

Q I'm sorry.

A -- and just wanted another summary of his condition.

Q Okay. And were you aware as to the reason of this individual's request as to why you were drafting a report?

A Sure. Yeah.

Q So you knew it was going to assist him in his --

A It was going to document -- or to support his claim for disability through Social Security.

Q Okay. So you were aware then that the federal government was going to rely on your opinion that you express in this letter in making a determination of his benefits?

A Uh huh (yes).

Q Now, Doctor, I believe at that time on April 16, 2002, in the first paragraph you basically found him severely limited in his ability to stand,

bend or sit for prolonged periods of time, and is unable to work as a result of that reason?

A Correct.

Q And then you identified a second problem, and perhaps even more severe problem, is that of his chronic anxiety and depression?

A Correct.

Q So as of April 16, 2002 you believed that the anxiety and depression was a more severe problem than the back condition?

A It was perhaps. Again -- you know, again, it's very hard to rank these things all the time, but, again, I think I wanted to stress the fact that probably at that point his anxiety was a major problem, and it was one of the things that was interfering with his ability to improve in that he was smoking, in that he was gaining weight, in that he -- you know, again, wasn't -- couldn't really deal with the possibility of surgery. So, yeah, it's a confounding factor in everything else.

Q Okay. And I believe the -- you identify a third problem, and that is of coronary artery disease?

A Right.

Q Now, you agree with me that he has

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coronary artery disease, but his heart is stable?
A His heart is stable at this point.
Q Okay. So the heart wouldn't have been disabling as of April 16 --
A As of April 16 it -- and as of today I don't think it's disabling.
Q Okay. Doctor, I believe you touched upon this in your direct testimony, but you say because of his severe anxiety he's even unable to even consider the possibility of back surgery as he's extremely fearful that the surgery will render him either paralysed or induce further myocardial infarction?
A Correct. That was his opinion especially back when the subject of surgery was first being thrown around after he saw Doctor Gelb, that he didn't -- he, in fact, told me that he just wouldn't consider it.
Q Doctor, you would agree with me that that fear is a complete irrational fear?
A The fear of a heart attack I think is an irrational fear. The fear of a not successful outcome, whether it's paralysis or just that you are left no better -- again, a standard line I use for my patients is that back surgery is a -- it's a

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court of last resort. When you can no longer go on, you go for back surgery because there is no guarantee of success, and there's no guarantee of improvement, and at times there's worsening. So that part of it I don't think is -- maybe paralysis is irrational, though, again, look at any informed consent that is required these days, and it's there. And if -- you know, if you a little hesitant to begin with, and you were told there's a risk of paralysis, a risk of impotence, a risk of bleeding, a risk of infection -- you know, these are what we are required to tell people these days when we do things to them. Even if they are not highly likely, we got to tell them, and that does scare people. And, again, you know, this was a year plus -- almost a year ago. Again, I'm not sure whether he would have that same opinion today, but at the time that this was all going on, and when he first saw Doctor Gelb -- because clearly you don't send somebody to a back surgeon if you already know that, you know, they don't want to have surgery, but it was after he met with Doctor Gelb, and after Doctor Gelb explained things to him that he said no way, not getting close to me.
Q Is the opinion that surgery will not help

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him or will help him?
A The opinion is that surgery may help him, and you can -- I don't know if you have Doctor Gelb's records in your file, but, again, you can read his actual things that he told him.
Q Doctor, I'm going back to the anxiety and depression. I believe you report that the condition has been what -- somewhat refractory to multiple medical interventions?
A Correct.
Q Does that mean --
A That we tried several different medications, and, you know, again, he had periodic worsening. I think these days it's a little better, but, again, at the point of that -- at the time of that letter, yeah, we had tried several things, and it still wasn't, you know, satisfactory.
Q Okay. So back in April about a year ago, April of 2002, you had tried various medical -- various medicines, and they weren't working that well?
A They were not getting the effect of totally relieving his anxiety, correct.
Q Presently that's better?
A I believe it is better.

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Q And has -- have you changed medications? Have you changed something to make it better?
A I think his circumstances have changed. He's -- like I said, he's basically been ejected from the restaurant, so he's not involved in that on a regular basis any more.
Q And to your knowledge, Doctor, he hasn't worked at the restaurant since July of 2000, right?
A Again, I don't know how -- you know, has he been in the restaurant, I'm sure he's been in the restaurant a lot. Now, what constitutes work is a whole other problem. I mean, that I don't know. Again, he's still the owner of the restaurant, he goes in there, he eats there, his family is there. Does he pick up something once when he's there, I have no idea, I don't spy on him.
Q Okay. So you --
A I don't know.
Q What you are saying is, Doctor, from July of 2000 to the present you are not really certain what his responsibility have been there?
A I'm not sure what his actual activities have been there.
Q Fair enough. Did you consider, Doctor, treating that fear that he expressed to you about

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his back surgery? Is that something you would treat as a physician treating people with psychiatric and --

A Well, we were, we were treating his anxiety. I mean, I don't know that there's a specific fear of back surgery treatment, but, I mean, again, we were -- we have continually altered his medications when it comes to his anxiety and things like that.

Now, if somebody doesn't want to have surgery, can you coerce them into it or can you -- again, you know, people have different thoughts about that, and, you know, again, is it irrational to fear back surgery? Well, maybe it's irrelevant to think you are going to get a heart attack from it, and maybe it's irrational to think you are going to be paralyzed, but is it irrational just not to want to have surgery, again, I don't know whether that's irrational. But, no, we didn't do any specific therapy in an effort to make him more agreeable to having surgery.

MR. WOLGEMUTH: Okay. Just go off the record for a second.

MR. SIMMERS: Off the video record. The is time is 5:34 p.m.

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(Off the record.)

MR. SIMMERS: Back on the video record. The time is 5:36 p.m.

(On the video record.)

BY MR. WOLGEMUTH:

Q Just so I understand it, Doctor, as of today, as of March 26, 2003, you are claiming that his back condition is his most disabling condition, and his psychiatric condition is secondary?

A Correct. I think that's the ranking as I now see it.

Q Okay. And, Doctor, when I took your deposition back in April 16, 2002, was your opinion different?

A I think at that point the anxiety symptoms were higher, and I think, you know, again, he was still -- again, when I look at him as a patient, I see beyond just these issues, and he's smoking, he's gaining weight, you know, I see the realm of the heart issue coming back onto the scene. It's not a present problem, but all that stuff I think was smoldering back then as well, that his weight was going up, he wasn't taking care of himself, he wasn't doing any activity of any kind, you know, and, again, I think that at that point my opinion of

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him was that the anxiety was the thing that was putting most of the risk into his life, and was more apparent to him at that point than anything else. It was also something did, again, kept him from considering surgery.

Since that time he hasn't been working. He seems to be doing better from a mental standpoint, but his back doesn't seem like it's getting any better. So I think those probably have flipped flopped over the last couple of years. The anxiety after the heart attack was severe for a while. It peaked and valleyed. We changed things around. Time has gone by, I think the anxiety has lessened, but, you know, it's still there. He still, you know, again, has symptoms, but I think the back is clearly his major disabling feature at this point.

Q Okay. And I just want to read a portion of your testimony, Doctor, just to make sure -- to make sure that this -- what I'm reading summarizes your current or you opinion as of April of 02. I'm reading from page 58, beginning on line 19:

My opinion, and I have stated several times, it's his psychiatric problems right now that are his primary limiting factor. His back problem

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runs a close second.

A That's what I -- yes, that's true.

Q Okay. And that was your opinion as of April of O2?

A That was my opinion as of a year ago, correct.

Q One or two more questions, Doctor. You had testified on direct that while treating individuals with severe psychiatric problems that you have on occasion referred them?

A Huh uh (yes), I have.

Q Where did you refer them?

A We have gotten a psychiatrist, Doctor Rosenthal, who's local now. Again, he doesn't see people quickly, and he doesn't seem them often, but he's available. You know, these are people that, you know, again, that we really have no great experience in managing, people who become psychotic, people who -- you know, schizophrenics, and things like that, and just, you know, people who just aren't functioning whatsoever.

But, yeah, we do have -- there's a couple -- there's the Stevens Center, but, again, the problem with the Stevens Center is it takes a long time to get in, and then the personnel is constantly

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changing, and there's a lot of dissatisfaction of what happened to people once they are there, and it's local. There are psychiatrists there, but, again, it's just not a great resource because there's no continuity, you see somebody for a month or two, and then it's a new body, it's a new face. And, again, they will take a fifteen minute, you know, how's it going, great, here's your medicines, good-bye. And so those options didn't see like they would add significantly to his care.

Q Okay. And you do agree that there are plenty of psychiatrists in the Harrisburg area?

A Again, I guess a better question is are there plenty of available psychiatric patient appointments available in Harrisburg, and that I don't know. There is certainly a shortage of psychiatric and mental health care in general in central Pennsylvania. I don't know how many psychiatrists there are in Harrisburg.

Q Okay. Fair enough, Doctor. Doctor, you had testified that -- excuse me -- that Mr. Mazzamuto is walking or his posture has -- includes like a little -- what do you call it, a hunch or a stoop?

A Yeah, he just -- he leans forward. He

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leans forward.

Q And you also I believe stated that you had seen the video that Mr. Mazzamuto had made of his day in the life of the --

A I did.

Q -- restaurant? When you viewed that video, did you observe him having that stoop or that problem, you know, with his back?

A In the video he actually seemed to have more of a stoop then I have observed him be here.

Q More of a stoop?

A More of a stoop.

Q Okay. Final question, Doctor. Mr. Mazzamuto has L3-L4 stenosis?

A He has L2 through L5 stenosis, worse at L3 -- maximum at L3 as of 1996.

Q Okay. You stated that correctly. I didn't mean to misrepresent it.

A That's okay.

Q The nerve roots that come out at L3-L4, what parts of the legs do they feed? What's -- the dermatomes or am I stating that correctly?

A Well, again, the thing is he's not -- he's not actually -- the nerve roots are not really what seems to be impinged as much as the spinal cord.

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Again, he doesn't have the impingement on the outside as my understanding where the nerves are coming out, the cord itself is being compressed.

So it's not as -- see, with a disk, you very clearly often just pinch a nerve at a particular place, which gives you one side symptoms in a very defined dermatomal distribution. But, again, my understanding from reading the reports is that his problem is more of the entire complex, if you look at it, is being pressed backwards. It's not necessarily just this nerve root being clipped.

So he's going to have -- again, he doesn't have a pure L2 radiculopathy or 2 -- L-4 because, again, when you have a ruptured disk, it's usually unilateral, it's on one side, and it's very focal.

He has diffuse bilateral leg pain. So -- so, again, it's not the same as a nerve root problem. I mean, I don't think his -- his is not a nerve root problem, it more of the cord itself is being pressed, and the cord has all the fibers from all the roots at that level down, so it could hit anything.

Q So if there's compression on the cord, that pressure could reflect on symptoms on any -- various types of distribution?

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A Well, on both sides because, again, the nerve -- it's the fibers that are in the cord, little pieces of them then branch out, and become the nerve roots. If you pinch it at the cord, what you can get any of those fibers regardless of which root they are going to eventually become. If you get pinched at this opening here, it gets one purely defined root, and, again, and that's the things that really lay out nicely in a dermatomal distribution, and that may clip off a particular reflex or be numb along the side, or the front, or the back of the leg, or go down the back, which is consistent with sciatica.

But he has bilateral symptoms, and he has them in both sides and they are more diffuse than that, and, again, my understanding of why that was is that, again, it's not a clean nerve root problem from a lateral compression, it's a cord being pinched by the central canal. That's why it's a central stenosis rather than a radicular symptom on one side or the other. He has bilateral symptoms.

MR. WOLGEMUTH: Thank you, Doctor. That's all the questions I have.

REDIRECT EXAMINATION

BY MR. ANGINO:

Q Doctor, we will try to kind of go through some things in a summary fashion.
Mr. Mazzamuto's date of birth is what?
A 5/25/55.
Q So May of 1955?
A Correct.
Q So that as of 1992 he would have been like forty-seven or so?
A 1992. No, he would have been thirty-seven.
Q Thirty-seven?
A Thirty-seven.
Q So in 1992 he was thirty-seven, and at that time he was already diagnosed as having the stenosis, is that correct?
A No. I think the diagnosis of stenosis came in 96. I think he's had -- he had back pain which predates my involvement, but when I fill out the forms and they say have you ever had a similar condition in the past, the back pain, looking back through the notes when Doctor Robinson took care of him, I found that he had had back pain back in 1992. I don't think it was diagnosed as spinal stenosis at that point.
Q I think the record will show by the time

your testimony comes forth that there was an x-ray back in 1992 that did show the stenosis, and if that is true, then there would have been an x-ray as early as 1992 when Mr. Mazzamuto was thirty-seven years of age showing already a stenosis, is that right?
A If there's an x-ray, yes, that's true.
MR. WOLGEMUTH: Okay. Objection.
MR. SIMMERS: Off the video record. The time 5:45 p.m.
(Off the video record.)
MR. WOLGEMUTH: I'm not aware of any 1992 x-ray, so I'm just objecting to preserve --
MR. ANGINO: Sure, preserve it. You will find though that there was something when he was in a hospital, but his back was x-rayed and there was because that's why they tried to get out of in 1996. They were contending that he knew --
MR. WOLGEMUTH: Knew of that condition of that or something?
MR. ANGINO: Yeah. So you will find that.
MR. SIMMERS: We are back on the video record. The time is 5:46 p.m.
(On the video record.)

BY MR. ANGINO:
Q Doctor, from what I understand from your testimony Mr. Mazzamuto's stenosis is a combination of a congenital condition where he has a narrow canal, and what we call degenerative arthritis, is that correct?
A Correct, but, again, the arthritis component would be more laterally, it doesn't seem to be contributing. It seems that the congenital part of it is just gradually increasing.
Q All right. So this congenital component as he got older it's getting narrower and narrower, is that right?
A Correct.
Q So that what we have is a man who already at thirty-seven is having back pain, is already showing up, if it does show up, in an x-ray as being stenosis already there. By the time 1996 comes by we are talking in terms of another four years, so he's now at forty-one years of age, and you were asked questions about some records back in 1996. This was the same time period where I asked you questions as to the MRI, and you read about the MRI, but if you look at your notes with regard to those early periods of time, I'm looking at what appears

to be -- it's cut off here -- 24 of 96. Do you know --
A Right.
Q That particular period of time here what it's saying is his legs have been getting numb. Last night he got out of bed. He fell down because of the numbness, is that right?
A Correct.
Q And if you turn to the next, it's May 29 of 1996, legs have a pinching sensation. Very weak yesterday. Lower back pain. Fell yesterday. Legs gave out, is that correct?
A Correct.
Q So we are talking now thirty-seven, forty-one. Now, four years later in the year2000 he is now forty-five years of age in the year 2000, is that right?
A That's correct.
Q And what's your opinion about is this going to continue to get worse, continue to get narrower, so when he's age forty-one narrower than it was when he was age thirty-seven?
A I think it will continue to progress.
Q Okay. And the situation is that back when he was thirty-seven in 1996 you did write some of

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those forms for the same New York Life Company that's involved in this case, is that right?
A That's correct.
Q And back in that period of time he was doing the same job, is that right?
A That's correct.
Q And, Doctor, we know from the records that they paid him for his loss in 1996.
MR. WOLGEMUTH: Objection.
MR. SIMMERS: Off the video record. The time is 5:49 p.m.
(Off the video record.)
MR. WOLGEMUTH: Again, what we did in 1996 is not relevant to what we did in 2000.
MR. ANGINO: All right. Back on the record.
MR. SIMMERS: Back on the video record. The time is 5:49 p.m.
(On the video record.)
BY MR. ANGINO:
Q Doctor, in 1996 the only condition that he had for which you filled out the forms was the back, is that right?
A That's correct.
Q By the time the year 2000 came about, and

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you started filling out the forms, you had three conditions then, is that right?
A That's correct.
Q You had the heart, you had the back, and you had the emotional element, is that right?
A That's correct.
Q And, Doctor, with regard to the back, from what you have told us the back was even worse than in 2000 than it would have been in the year 1996, he's four years older, and now he also has an emotional component, is that right?
A That's correct.
Q Would you expect the emotional component to make his condition worse as far as doing a job of any sort?
A When it's bad, yes.
Q Okay. Doctor, I have been listening patiently for the questions that have been asked of you, and when I was out in your waiting room there I saw a woman in a wheelchair. I assume occasionally you have patients who are in wheelchairs, is that right?
A That's correct.
Q And those patients in wheelchairs probably can call a supplier, and get certain supplies in, is

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that right?
A Some of them who are mentally fit, yes, they can.
Q And a number of the questions that defense was asking you about can you do some books, can you call some suppliers, can you -- even quadriplegics can do that, is that right?
A With the right equipment, sure.
Q Sure. So even somebody who has no arms, has no legs certainly can do the types of things that he was asking you questions can Mr. Mazzamuto do, such as do some books or make some calls or even supervise, is that right?
A Under extreme conditions, I guess sure.
Q Sure. So when you were asking questions, and you were filling out forms, when you use the world total disability, were you using a practical definition of whether somebody can go out and get a job and do the job?
A My opinion was for the global -- the global assessment of the entire patient as to whether or not he could fulfill his job requirements or do his job.
Q And as far as you understood his job, it was a man who was standing behind a counter, it was

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a man who was walking around, it was a man who was cooking at times, it was a man who was lifting at times, as well as ordering some things, and picking up the orders, it involved that global -- that -- all of those things, is that right?
A That was my understanding of his job.
Q And so that if he couldn't do all of those things, then it was your opinion he was totally disabled, is that right?
A That's correct.
Q And as far partial disability, would you assume at least from a practical standpoint since we are dealing with potentially a legal issue, is that you can only do a part of your job, but you still can put in an eight-hour day, you can still do forty hours a week, somebody will still hire you, is that right?
A Yes. Partial disability in my way of thinking is that you have restrictions as to what you are allowed to do, but you still fulfill most of the requirements of your job.
Q One thing I heard that was really strange was he said now the MRI was taken in 1996, but the EEG was taken later.
MR. WOLGEMUTH: Objection.

MR. ANGINO: Do you remember that question?
MR. WOLGEMUTH: It was an EMG.
MR. ANGINO: Okay. I'm sorry. I will rephrase it.
BY MR. ANGINO:
Q Doctor, do you recall a question being asked of you that an MRI was taken in 1996, but an EEG --
A EMG.
Q -- EMG, was taken later?
A I do.
Q The fact that an MRI was in 1996, if you would take that test later, the condition would not be better, is that right?
A My assumption would be it would either be the same or worse.
Q That's right. So actually the fact that the MRI was 1996, and we are now into the year 2003, the assumption is that his back condition from an MRI is worse or at least the same, is that right?
MR. WOLGEMUTH: Objection. Objection.
MR. SIMMERS: Off the video record. The time 5:53 p.m.
(Off the video record.)

MR. WOLGEMUTH: You are asking the Doctor to speculate. There is no current MRI.
MR. ANGINO: Okay. Back on the record.
MR. SIMMERS: Back on the video record. The time is 5:53 p.m.
(On the video record.).
BY MR. ANGINO:
Q Doctor, are you certain as far as reasonable certainty in medicine could be that, if an MRI showed a condition in 1996, and you took an MRI today in 2003, it would be at least as bad, if not worse?
A In this condition, yes.
Q Yes. You don't get better from this condition as far as an MRI shows?
A The bony changes don't change, no.
Q And, Doctor, there is a mention -- a person you mentioned on several occasions, Doctor Gelb, is it?
A Doctor Gelb. G-E-L-B.
Q And Doctor Gelb is an orthopedic surgeon, is that right?
A He was the orthopedic surgeon in charge of back surgery at Hershey Medical Center.
Q So here's a man with the credentials of

being an orthopedic surgeon in charge of back surgery at Hershey Medical Center, and when I had asked you questions earlier about when you were looking for somebody for specialist to do surgery, you would refer them to orthopedic surgeons, and that is the type of person that Doctor Gelb was, is that right?
A Either an orthopedic surgeon who does back speciality or a neurosurgeon. I think even then you want to go to somebody who specializes primarily on the back since there are orthopedic surgeons who spend most of their time doing hips and knees and shoulders, but Doctor Gelb was a back only gentlemen.
Q And Doctor Gelb would be the type of physician upon whom you would rely, refer, and utilize in your treatment and care, is that right?
A Correct.
Q And Doctor Gelb confirmed, did he not, your diagnosis that he has this stenosis, is that right?
A It was his opinion in the letter that he had the stenosis, and that his symptoms were coming from it, and that surgery would be an option.
Q So that basically he supported what you

were doing in terms of prescribing medication for back pain coming from a stenosis, is that right?
A He did.
Q But he said there might be another option, is that right?
A He said that surgery might be another option.
Q And as far as surgery, you said there are various reasons to go with surgery or not to go with the surgery, and a decision either way would be a rationale one, is that right?
A That's correct.
Q Now, much of the questioning asked of you dealing with the emotional element, when you work with your medical records, and somebody comes in, and they say to you I'm depressed, or I'm irritable, or my wife and I are having some real problems emotionally, and things like that, do the medical records generally show what the effect of the anxiety is on someone's daily life?
A Sometimes they do, and sometimes they don't.
Q Okay. But when you use the word labile, what do you mean?
A Rapidly changing.

Q So that one minute you are happy, the next minute you might be sad, you may be responding to something that's insignificant in an abnormal way, would that be fair?
A I think that would be correct.
Q And with regard to that, assuming that a lot of the questions asked of you dealt with the period of 2000, 2001, 2002, and now we are into 2003, assuming that Mr. Mazzamuto is not even working at that time, whether the emotional condition is primary or close or whether the back is a close second, you are giving these relevant positions not in terms of his work, but in terms of the way he appears, is that right?
A That's correct.
Q So that although the questions asked of you in a case of law where we are dealing with disability could be misinterpreted by the jury as to have to do with his work, you were using it not in a work context?
A That's correct.
MR. ANGINO: I have no further questions.
MR. WOLGEMUTH: Three or four questions, Doctor.

RECROSS EXAMINATION

BY MR. WOLGEMUTH:
Q Counsel just asked you a question as to, you know, if you were reviewing Mr. Mazzamuto's position at his restaurant to include things like lifting, and cooking, and ordering, and supervising, and look at it globally, I believe your testimony is that you believe he is unable to perform those duties?
A That's correct.
Q Now, if you were wrong in your assessment of what he does there, do you agree that your opinion would be incorrect?
A Well, if my opinion of what he does is wrong in that he is current -- or he is able -- he's doing all those things, well, yeah, it would be wrong.
Q I think you are misunderstanding my question. If -- in fact, Doctor, if Mr. Mazzamuto doesn't do or wasn't doing a lot of lifting, and a lot of cooking, and a lot of heavy work like that prior to, you know, his heart attack in July of 2000, if he wasn't doing those duties, but doing more administrative and more supervisory duties, would you agree that the opinion you are rendering pursuant to Mr. Angino's question would be

incorrect.
MR. ANGINO: I have to object just because you left out the main thing, the standing.
MR. WOLGEMUTH: Okay. I will do the standing.
MR. ANGINO: Because that's the principal one, yeah.
MR. WOLGEMUTH: Okay. I will include standing as one of his --
THE WITNESS: Right. It could be wrong under some conditions though. Again, there have been times when his emotional state would have prevented him from doing some of those things, and there are times when probably it wouldn't have.
BY MR. WOLGEMUTH:
Q Okay. So, Doctor, what I hear you saying that -- that presently, you know, again, looking at all those job duties, Mr. Mazzamuto could do some of those duties?
A He could do some of those duties for some period of time. Now, what the result of that would be on whether his symptoms would flare again, would the anxiety rebound, would his back get worse, I don't know.
Now, as I said before, anybody can do

almost anything now and again for a short period of time in an extreme circumstance, but when I'm looking at this disability, my understanding is is it's something he can kind of do day in and day out on a regular basis, and again, I think he could probably do some of those things some of the time, but, you know, based on what he -- where he's been before, you know, if he's back there doing administrative things, and suddenly something is going wrong, and he can't really do anything about it because his back holds him back, could he get all emotional again, could he get -- you know, fly off in a rage, could he do all those things that he was doing for a period of time, I think it's possible to go back. It's possible it couldn't, and I don't know that. I can't see the future.
Q Okay. And, Doctor, Mr. Angino had asked you about, you know, the development of stenosis, and the progression of stenosis. Would you agree with me that surgery could relieve the effects of stenosis?
A Surgery can relieve it in many cases, but, again, the result are always you don't know.
Q Okay. And do you agree, Doctor, that something like steroid shots that, in fact,

Mr. Mazzamuto gets, could also alleviate the symptoms of stenosis?

A Well, they can, but he has had numerous rounds of them, and they have been short-lived at best, and they come back. Stenosis is harder to deal with than a herniated disk because, again, you are dealing what a bony problem, and bones don't regress. There's always a little inflammation around the bones, the soft tissues could swell, and that's why you can get these varying symptoms, but the problem is the bone in a stenotic canal it's always bone, it's always hard, and it doesn't change. It doesn't shrink, it doesn't move, it doesn't go anywhere. It's the surrounding tissues that you might have a little impact with.

With a ruptured disk because that's a gelatinous material, things like steroid shots and stuff are often much more beneficial, and can you give you much more long lasting success, but Mr. Mazzamuto has had numerous epidural steroid shots, and even when he gets them now, sometimes they seem to give him some benefit for a while, sometimes they don't. But this is a harder thing to treat with medicine and epidural steroid injections because of the nature that it's a bony encroachment,

it's not a soft tissue problem primarily.

Q Okay. And the surgery, what would they do, they would try to take out the bony impingements, is that --

A No. Well, usually what they do is they actually take off the backs of the spine here to open up the canal from the other side. Now, can they get in there and try to shave things away, I don't know the details of that kind of surgery, but when they do a decompression, they usually take out some of these posterior elements because, again, it's being pushed from this side, so if you pull thing off on that side, it gives it more room, more places to expand.

MR. WOLGEMUTH: That's all the questions I have, Doctor.

MR. ANGINO: Thank you.

MR. SIMMERS: This concludes the deposition. The time is 6:03 p.m.

I hereby certify that the proceedings and evidence taken by me in the within matter are fully and accurately indicated in my notes, and that this is a true and correct transcript of same.

Mary Ann Still

SOCIAL SECURITY ADMINISTRATION
Office of Hearings and Appeals

DECISION

IN THE CASE OF

VINCENZO MAZZAMUTO
(Claimant)

CLAIM FOR

Period of Disability and
Disability Insurance Benefits

(Wage Earner)

196-56-5744
(Social Security Number)

INTRODUCTION

On April 24, 2001, the claimant protectively filed an application for disability insurance benefits. The claim was denied initially, and a Request for Hearing was timely filed on October 1, 2001. Because there is sufficient evidence to establish disability based upon the evidence in the record, an oral hearing was not held. The claimant alleges disability beginning July 22, 2000 due to stenosis of the spine, a heart attack, and stress (Ex. 1E). Trudy H. McGraw, an attorney, represents the claimant in this matter.

The general issue is whether the claimant is entitled to a period of disability and disability insurance benefits under Sections 216(i) and 223 of the Social Security Act. The specific issue is whether he is under a disability, which is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

With respect to the claim for disability insurance benefits, there is an additional issue pertaining to insured status. A review of the claimant's earnings record reveals that he has earned sufficient quarters of coverage to remain insured at least through the date of this decision.

After careful consideration of the entire record, I conclude that a fully favorable decision on behalf of the claimant is appropriate at step five of the sequential evaluation process.

EVALUATION OF THE EVIDENCE

Exhibit B

The claimant is a 47-year-old individual with a limited seventh grade education and past relevant work as a restaurant owner. He has not engaged in substantial gainful activity at any time since the alleged onset date.

The claimant has the following medically determinable severe impairments: degenerative disc disease and coronary artery disease. The medical evidence of record establishes that the claimant has a significant history of low back pain since at least 1996. The medical records reveal that the claimant experiences severe low back pain, which has been chronic and unrelenting despite numerous aggressive interventions. Treatment records show that the claimant has been on multiple medications, that he has received physical therapy, that he has received treatment from a pain clinic, and has received numerous local epidural steroid injections, all of which have only minimally attenuated his symptoms. In addition to debilitating back pain, the evidence also establishes that the claimant suffered a myocardial infarction and required cardiac catheterization on July 24, 2000. Although the evidence establishes that the claimant's coronary condition is relatively stable, he continues to experience debilitating back pain. An August 4, 2000 medical report indicates that the claimant was experiencing worsening back pain with radiculopathy into the posterior aspect of both thighs. On March 12, 2001, the claimant was still complaining of back pain going down his right buttock and down into his leg as well as anterior right thigh burning. It was noted that walking and sitting for any length of time seem to aggravate this condition. Upon examination, there was tenderness to palpation in the lumbosacral spine. A lumbar spine MRI performed on October 17, 2001 revealed degenerative desiccation and diffuse degenerative bulge of the L3-4 and L4-5 intervertebral discs. The neural canal was significantly narrowed at L3-4 consistent with focal spinal stenosis. A December 19, 2001 treatment note indicates that the claimant has difficulty sleeping because of the pain. Daniel E. Gelb, M.D. indicated in an orthopedic evaluation report of January 4, 2002 that the claimant continues to have primary back pain with significant symptoms in the legs, which occur either with prolonged standing or sitting. Dr. Gelb concluded that the claimant is a candidate for lumbar decompression. Douglas J. Bower, M.D. indicated in a report of January 31, 2002 that the claimant's most significant problem is his low back discomfort. Dr. Bower indicated that the claimant has ongoing discomfort, both with sitting and standing and that he is unable to lift. Dr. Bower concluded that the claimant was incapable of working (Exs. 1F-6F and 12F-15F).

The claimant stated in the record that he experiences bad back pain with pinching, trembling, and a burning sensation in his legs. He reported that sitting and standing for any length of time aggravate his pain and noted that he must rest between activities. The claimant reported that pain disturbs his sleep regularly and that pain interferes with his ability to concentrate. He indicated that medications cause constipation as a side effect.

The allegations of the claimant are credible based on the medical evidence and the criteria of 20 CFR 404.1529 and SSR 96-7p.

The claimant does not have an impairment that meets or equals the criteria of any listed impairment. A determination must therefore be made of whether he retains the residual functional capacity to perform the requirements of his past relevant work or can adjust to other work.

I realize that the claimant also has a severe anxiety disorder. However, since a fully favorable decision is appropriate based on physical impairments alone, functional limitations attributable to the claimant's mental impairment have not been assessed.

The evidence of record supports a finding that the claimant retains the residual functional capacity to lift or carry and push or pull 2-3 pounds occasionally and no weight frequently, stand or walk 1 hour per 8-hour workday and sit 4 hours per 8-hour workday with a sit/stand option. Additionally, he is only able to engage in bending, stooping, kneeling, climbing, crawling, or crouching on an occasional basis. Based on these limitations, the claimant retains the residual functional capacity for significantly less than the full range of sedentary work.

I have given significant weight to the above-mentioned opinion dated April 16, 2002, of Dr. Bower finding the claimant unable to work (Ex. 15F), as it is supported by the clinical findings contained in the record as well as the degree of treatment required. As for the opinion dated June 18, 2001 of the State Agency medical consultant finding that the claimant retained the capacity to perform light work activity (Ex. 8F), it has been given limited weight as it is inconsistent with the other substantial evidence, some of which was unavailable for review by the State Agency consultant.

In his former work as a restaurant owner, the claimant was required to perform skilled light exertional level work activity. Because the claimant is limited to significantly less than the full range of sedentary work, he is precluded from the performance of his past relevant work.

As the claimant has demonstrated that he lacks the residual functional capacity to perform the requirements of any past relevant work, the burden shifts to the Social Security Administration to show that there are other jobs that the claimant can perform. This determination is made in conjunction with the Medical-Vocational Guidelines of Appendix 2 of Subpart P of the Regulations (20 CFR Part 404). Appendix 2 contains a series of rules that direct a conclusion of either "disabled" or "not disabled" depending upon the claimant's age, education, work experience, and residual functional capacity.

Born May 25, 1955, the claimant was 44 years old on July 22, 2000. For the purpose of this decision, he is considered to be a younger individual. He has a limited education and has a skilled work background. However, considering the nature and extent of the claimant's functional limitations, it is reasonable to conclude that there are no occupations to which the claimant's acquired work skills could transfer.

The claimant's capacity for the full range of sedentary work is reduced by additional limitations that narrow the range of work he can perform. Considering these limitations within the guidelines of Social Security Ruling 96-9p, there are no occupations with jobs existing in significant numbers in the national economy which the claimant could perform. A finding of "disabled" may therefore be reached within the framework of Medical-Vocational Rule 201.25.

In accordance with a finding that the claimant has been under a disability beginning July 22, 2000, he is entitled to disability insurance benefits on the basis of his application protectively filed on April 24, 2001.

FINDINGS

After careful consideration of the entire record, I make the following findings:

1. The claimant has not engaged in substantial gainful activity since July 22, 2000.

2. The medical evidence establishes that the claimant has the following severe impairments: degenerative disc disease and coronary artery disease.

3. The claimant has no impairment that meets or equals the criteria of any impairment listed in Appendix 1, Subpart P, Regulations No. 4.

4. The claimant's assertions concerning his ability to work are credible.

5. The claimant retains the residual functional capacity to lift or carry and push or pull 2-3 pounds occasionally and no weight frequently, stand or walk 1 hour per 8-hour workday and sit 4 hours per 8-hour workday with a sit/stand option. Additionally, he is only able to engage in bending, stooping, kneeling, climbing, crawling, or crouching on an occasional basis. Based on these limitations, the claimant retains the residual functional capacity for significantly less than the full range of sedentary work.

6. The claimant is unable to perform the requirements of his past relevant work.

7. The claimant's residual functional capacity for the full range of sedentary work is reduced by additional limitations.

8. On July 22, 2000, the claimant was a younger individual.

9. The claimant has a limited education.

10. The claimant has a skilled work background. However, considering the nature and extent of the claimant's functional limitations, it is reasonable to conclude that there are no occupations to which the claimant's acquired work skills could transfer.

11. Considering the claimant's additional limitations, he cannot make an adjustment to any work that exists in significant numbers in the national economy; a finding of disabled is therefore reached within the framework of Medical-Vocational Rule 201.25.

12. The claimant has been under a disability, as defined in the Social Security Act, since July 22, 2000 (20 CFR §404.1520(f)).

DECISION

It is my decision that, based on the application protectively filed on April 24, 2001, the claimant is entitled to a period of disability commencing July 22, 2000, and to disability insurance benefits under Sections 216(i) and 223, respectively, of the Social Security Act.

EDWARD T. MORRISS
Administrative Law Judge

JUL 25 2002
Date

New York Life Insurance Company
New York Life Insurance and Annuity Corporation
(A Delaware Corporation)
NYLIFE Insurance Company of Arizona
(Not licensed in Every State)
PO Box 6916 Cleveland OH 44101, (800) 695-9873
The Company You Keep

COPY

June 14, 2002

Vincenzo Mazzamuto
501 Limestone Rd
Carlisle PA 17013

Policy: 44 904 932
Claim: 368 799

Dear Mr. Mazzamuto:

I am writing in reference to the above claim for Waiver of Premium Disability benefits on the above policy. Thank you again for your patience while we reviewed this life claim.

The Waiver of Premium Benefit provision of your policy contract states, in part, that total disability means that because of disease or bodily injury, you cannot do any of the essential acts and duties of your job or any other job for which you are suited based on schooling, training or experience. If you are able to do some, but not all of these acts and duties, disability is not total.

However, the Company has taken a more liberalized view of total disability as it pertains to an insured's occupation. This liberalization allows us to waive premiums for up to two years after the onset of the disability based on your being totally disabled from performing the material duties of your occupation as a restaurateur. This is an administrative exception and does not affect the terms of your contract.

Therefore, I am pleased to inform you that we will waive the premiums on the above policy from July 22, 2000, the first date we have evidence of your total and continuous disability (under the liberalized terms stated above), to the premium due August 4, 2002.

A check for a refund of the August 2000 and 2001 Annual premiums has been sent under separate cover.

Mr. Mazzamuto, I wish you continued success in your future endeavors. Please let me know if you have any questions.

Sincerely,

Therese A. Sindelar Ext 8724

cc: Salvatore Ferrigno V44

Exhibit C

the INSURANCE FORUM®

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OUR 30th YEAR

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Vol. 30, No. 6 **June, 2003**

UNUMPROVIDENT CORPORATION AND THE GEORGIA COMMISSIONER

UnumProvident Corporation, through its operating subsidiaries, dominates the disability insurance market in the United States. The companies' controversial claims practices are discussed in our February 2003 special issue on UnumProvident and our April/May 2003 special issue on insurance claims.

On March 19, John W. Oxendine, the insurance commissioner of Georgia, issued an order stemming from a market conduct examination of the UnumProvident companies' claims practices. The order raises procedural questions, and UnumProvident issued a distorted press release about the order.

The Order

Commissioner Oxendine fined four UnumProvident companies a total of $1 million, ordered them to change their claims practices, and placed them on probation for two years. Also, he will continue to examine their claims practices during the probationary period, and the continuing examination will include quarterly reviews of Georgia claims that are denied. The text of the order is in the box on page 215.

The order did not name Colonial Life & Accident Insurance Company (Columbia, SC), a subsidiary of UnumProvident. In response to my inquiry, a spokesman for the Georgia insurance department said Colonial was not included in the examination because the department had not received complaints about Colonial's claims practices.

Unofficial Comments

Articles about Commissioner Oxendine's order appeared in several news outlets. The articles included comments that were attributed to him, but that did not appear in the order or in the press release accompanying the order. Some of the comments were in quotation marks. Others were not, suggesting they were paraphrases of what he said. Here are the unofficial comments attributed to Commissioner Oxendine:

- **People were being denied claims unfairly.**
- **Policyholders complained about disability claims being rejected or, once approved, being canceled later.**
- **We believe there was a corporate philosophy of pushing the envelope to the edge, of looking for every technicality possible to get out of paying the claim.**
- **We told them they are going to change the way they do business and change their fundamental corporate philosophy.**
- **No longer will claims personnel override medical decisions.**
- **The department met resistance initially, but the company became more cooperative when I started imposing a fine of $5,000 a day.**
- **The quarterly review process is extremely unusual. I've never seen it done in the country before.**
- **The fine is the largest ever levied by the insurance department.**
- **UnumProvident wasn't accused of breaking the law.**

CONTENTS OF THIS ISSUE

Exhibit D

The Confidentiality Issue

In our February 2003 issue, which went to the printer in late December, I mentioned the Georgia department's market conduct examination of the UnumProvident companies' claims practices. When I called the department in the middle of December, the spokesman said he expected the report of the examination to be made public by the end of December. When I called in early January, he said he expected the report to be made public by the end of January. When I called in early February, he said he did not know when the report would be made public.

After I received the order, I filed a request under the Georgia statute governing access to public records. I asked for a copy of the report covering the initial phase of the market conduct examination, now that the initial phase is completed. The request was denied because the examination "has been extended for an additional period of two years," and because "examination reports and records of pending examinations are not available for public disclosure until they are finalized." Describing the examination as "pending" at this late date (the examination began more than two years ago) is a clever way to keep the report confidential for at least two more years.

Commissioner Oxendine should have treated the initial phase of the market conduct examination as complete upon issuance of the order, and should have made the report on the initial phase available to the public. His failure to do so deprives the public of timely access to important information.

The Missing Allegations

Allegations that the UnumProvident companies' claims practices violate Georgia statutes or regulations are missing from Commissioner Oxendine's order. Indeed, as indicated above, he was quoted in a news article as saying he was not accusing the companies of breaking the law. In the absence of such allegations, imposing fines raises questions about the procedures followed by the Georgia department.

What was the basis for the fines? What purposes were served by the fines? Why did the UnumProvident companies pay the fines? Surely the fines were not "necessary at this time for the protection of Georgia consumers," as stated in the order. As for punishment or deterrence, fines totaling $1 million are no more than a light slap on the wrist for an organization with annual premium revenue of more than $6 billion.

Under normal procedures, the regulator alleges violations, and the company denies the allegations. If the matter is settled, the agreement would involve a fine or other punishment, and the company would not admit to the violations. If the matter is not settled, the matter would go to an administrative law judge or a court. In short, the absence of allegations in this instance is extraordinary.

Avoiding the Issue

Because of the missing allegations, I inquired about the basis for the fines. In response, the department spokesman said the parties agreed on the fines. That response avoids answering the question.

I think UnumProvident agreed to the fines—and may even have suggested the fines—for three reasons. First, UnumProvident wanted the order to contain no allegations, because allegations by a regulator might have been damaging to the company in its defense of the many lawsuits relating to claims practices. Second, UnumProvident wanted the report of the market conduct examination to remain confidential. Third, UnumProvident wanted to help Commissioner Oxendine issue an order that would appear significant.

The UnumProvident Press Release

UnumProvident issued a distorted press release about Commissioner Oxendine's order. UnumProvident referred to the order as an "agreement" in the title of the press release ("UnumProvident Reaches Agreement with Georgia Department of Insurance") and throughout the text of the press release. UnumProvident referred to the $250,000 fine imposed on each of the four companies as a "settlement amount." UnumProvident failed to mention that the companies were placed on probation. UnumProvident said the "settlement amount stemmed largely from early delays on the part of the company in responding to requests for information," and failed to mention the practices that the companies were ordered to change. UnumProvident characterized the market conduct examination as a "standard oversight function," and failed to mention that complaints triggered the examination. UnumProvident blamed the problems

The Insurance Forum is published monthly by Insurance Forum, Inc., P. O. Box 245, Ellettsville, Indiana 47429-0245. www.theinsuranceforum.com. Telephone (812) 876-6502. ISSN 0095-2923. The subscription price is $90 per year.

Reprints of this 8-page June 2003 issue are $5 each. They are $2.50 each when at least 20 reprints of the issue are sent in one shipment. Further discounts apply to orders of at least 250 reprints.

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fits of $8.5 million. Thomas R. Watjen, who was vice chairman and chief operating officer, was appointed president and chief executive officer on an interim basis. Two outside members of the board of directors were appointed co-chairmen. Another outside director was appointed to chair a search committee of the board, which will consider Mr. Watjen as well as external candidates.

Neither the UnumProvident press release nor the newspaper articles I have seen mention Ralph W. Mohney, who Mr. Chandler brought in "to move Provident from a claim payment to a claim management approach." Whether the firing of Mr. Chandler and the appointment of a new chief executive will produce substantive changes in the UnumProvident companies' claims practices remains to be seen.

Let's hope so
GKR

INCOME TAXATION OF DISTRIBUTIONS TO POLICYHOLDERS IN DEMUTUALIZATIONS

The Internal Revenue Service (IRS) and the mutual insurance companies that demutualized in recent years told policyholders about the income tax treatment of the distributions the policyholders received in exchange for their ownership interests in the companies. Early this year, C. D. Ulrich, a certified public accountant who has studied the subject carefully, brought to my attention his belief that the treatment mentioned by the IRS and the companies is incorrect, that the treatment is extracting from policyholders billions of dollars of unwarranted taxes, and that policyholders who have already paid taxes on distributions should file amended tax returns and seek refunds.

When Mr. Ulrich contacted me, I found it difficult at first to believe that there might be no statutory authority for the tax treatment mentioned by the IRS and the companies. After studying the matter, however, I believe that the treatment mentioned by the IRS and the companies is open to serious question. The purposes of this article are to describe the tax treatment mentioned by the IRS and the companies, discuss the absence of statutory support for that treatment, describe the tax treatment Mr. Ulrich suggests, and indicate what a policyholder might do.

A Note on Terminology

A mutual insurance company is a corporation that is engaged in the business of insurance, has no shareholders, has policyholders who are customers with ownership interests, and is operated exclusively for the benefit of the policyholders. I say individual policyholders have "ownership interests"—rather than saying they are owners—because they have some but not all the characteristics of owners. A policyholder has the right to vote on certain matters and the right to share in certain distributions, but those rights terminate when his or her policy terminates. In short, a mutual insurance company's policyholders as a group own the company, and individual policyholders of the company have ownership interests.

Some mutual insurance companies, including especially those who downplay the rights of the policyholders, call the policyholders "members" and say they have "membership interests." The IRS uses the phrases "equity interests" or "proprietary interests." In this article, except when quoting others, I use the expression "ownership interests."

The IRS/Company Approach

Here, in brief, is how the IRS and the demutualizing companies explain the income tax treatment of demutualization distributions. For the policyholder who receives shares of stock, there is no immediate taxable income; however, when the shares are sold, the policyholder's basis in the shares is zero and the full amount received in the sale is a capital gain. For the policyholder who receives cash, the full amount received is taxed immediately as a capital gain. In either case, whether it is a long-term capital gain or a short-term capital gain depends on when the policyholder first acquired his or her ownership interest; because the typical policyholder purchased his or her first policy in the company more than one year before the distribution, the amount received in most instances is a long-term capital gain. In this article, I refer to the tax treatment described by the IRS and the companies as the "zero basis approach."

One Company's Explanation

Provident Mutual Life Insurance Company (Provident) demutualized in 2002 and immediately became a subsidiary of Nationwide Financial Services, Inc. (Nationwide). In exchange for their ownership interests, eligible Provident policyholders received shares of stock in Nationwide.

Nationwide said in an information brochure sent to each policyholder with the distribution that the value of his or her ownership interest in Provident was $28.0146 (the volume-weighted average sales price per share during the 15 trading days ended September 24, 2002) multiplied by the number of shares allocated to the policyholder. The joint proxy statement/prospectus (proxy) sent to policyholders in August 2002, in the section entitled "Material Federal Income Tax Consequences," said on page 58 that "your tax cost or 'basis' for any shares you receive will be zero." The law firm of Debevoise & Plimpton provided a tax opinion to Provident's board of directors. The opinion, dated August 2, 2002, was in the proxy and included this sentence:

on "disruptions" associated with the 1999 merger, and failed to mention the continuing complaints about the companies' claims practices.

The Chandler Firing

Commissioner Oxendine's order was consented to by J. Harold Chandler, chairman, president and chief executive officer of UnumProvident and its subsidiaries. Twelve days later, on March 31, UnumProvident announced that the board of directors fired Mr. Chandler. The firing was not necessarily related to the Georgia situation or any other single development.

In accordance with his current employment contract, which was executed in 1999, Mr. Chandler will receive $17 million—severance pay of $8.5 million (three times base salary and bonus) and pension bene-

COMMISSIONER OXENDINE'S ORDER (MARCH 19, 2003)

WHEREAS, the Commissioner of Insurance (hereinafter the "Commissioner") commenced an examination of the records and activities of Unum Life Insurance Company of America, The Paul Revere Life Insurance Company, Provident Life and Accident Insurance Company, and Provident Life and Casualty Insurance Company (hereinafter the "Respondents"); and

WHEREAS, pursuant to Georgia law, the Commissioner may use information discovered or developed during the course of an examination in furtherance of any legal or regulatory action which the Commissioner may, in his sole discretion, deem appropriate; and

WHEREAS, during the initial period of examination, the Commissioner has determined that certain issues associated with the handling of claims, complaint resolution, and record maintenance warrant further examination; and

WHEREAS, notwithstanding the further examination of Respondents as set forth herein, the Commissioner has determined that certain actions are necessary at this time for the protection of Georgia consumers.

NOW THEREFORE, upon consideration thereof, the Commissioner hereby places Respondents on regulatory probation for a period of 2 years. The terms are as follows:

1. Each of the Respondents shall immediately pay a monetary penalty in the amount of $250,000.

2. The market conduct examination of the Respondents, initiated by Certificate 2000-MC15 and initially covering the period of January 1, 1999 through November 30, 2000 (the "initial exam period") shall be extended and continue through the period of regulatory probation. The scope of the examination will include further investigation of certain issues identified during the initial exam period and the monitoring of current claims handling practices as described below.

3. As part of the continuing market conduct examination of the Respondents, a quarterly review of Georgia claims by a qualified examiner with knowledge and experience in the area of disability insurance to be selected by the Commissioner shall be performed for each quarter for 2 years from the date of this Order. Claims to be reviewed will be claims and/or complaints (whether previous, pending, or future) submitted by Georgia residents, and the claims and/or complaints selected shall include but not be limited to consumer complaints received by the Commissioner and Respondents and random samples of denied claims.

4. Respondents agree to be sensitive to claims in which a narrow interpretation of policy provisions or legal principles may lead to an unfair result. Respondents will consider, and, on a case-by-case basis, will make exceptions to such narrow interpretations, particularly in claim cases involving more subjective determinations, in order to accomplish a fair result. Any such exception will be consistent with the medical findings in the case, normal and customary application of the relevant policy provisions and applicable legal principles.

5. Claims personnel will not overrule medical opinions relating to the disability status of a claim that is provided by a more highly trained and/or qualified professional without concurrence of an equally trained and/or qualified professional.

6. Respondents shall provide improved communications to claimants regarding denial and the availability of the appeals process. Such communications shall accurately and clearly explain the disability definition and basis for denial and refer to specific language in the policy that is relevant to the decision.

7. Respondents shall maintain copies of applicable policy forms or provisions in the claim files. Additionally, Respondents shall adhere to Respondents' policy of maintaining copies of medical records in the claim files.

8. Respondents shall improve tracking and availability of claims files and complaint files.

9. Respondents shall meet all applicable time standards for appropriately responding to claims filings and correspondence.

10. Respondents shall respect the privacy of claimants and will, in the process of collecting, using and determining disclosure of claim information to any third parties, act in accordance with applicable laws, regulations, policy provisions and claim policies of the Respondents.

11. Respondents shall bear all costs associated with the extended examination.

FURTHER, by consenting to this Order, Respondents agree to comply with all of the above-referenced terms of this Order and to comply with all applicable Georgia law and regulations. Respondents admit no violation of Georgia law or regulation and do not admit that the inclusion of any matter in this Order implies failure of prior compliance.

FURTHER, all terms and conditions contained herein are hereby **ORDERED**, this 19th day of March, 2003.

[*Editor's note*: Commissioner Oxendine signed the order. J. Harold Chandler, who was chairman, president and chief executive officer of the four UnumProvident companies at the time, consented to the order.]

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Exhibit E

0556

UNUM

Protecting everything you work for

April 20, 2001

Peter J. Russo
Attorney At Law
Suite 200, 5010 East Trindle Road
Mechanicsburg, PA 17050

Re: Vincenzo Mazzamuto
Claim # 13-H3236167-002

Dear Mr. Russo:

Thank you for the courtesies you extended me during our recent telephone conversation. As we discussed, we would be in contact with you, in writing to outline the status of Mr. Mazzamuto's claim. We would like to take this opportunity to do so.

According to Mr. Mazzamuto's policy, Total Disability means that the insured can not due the substantial and material duties of his or her regular job. The cause of the total disability must be an injury or sickness.

Residual Disability means, during the elimination period, that due to an injury or sickness as define in the policy, the insured:

A. is not able to do one or more of the substantial and material duties of his or her regular job; or
B. directly and apart from any other cause, has a loss of income as defined in the rider of at least 20%.

After the elimination period has been satisfied, residual disability means the insured has a loss of income as defined in the rider of at least 20%. The loss of income must result directly from the same or related injury or sickness used to satisfy the elimination period. The loss of income must not result from any other cause.

On Mr. Mazzamuto's initial claim form, received in our office on December 15, 2000, he indicated that his employer's name was Vinny's Restaurant, Inc. and that his duties consisted of "executive 50% and office 50%." He indicated that he was the president. On an Insured's Statement of Occupational Duties and Employment issued with the claim form, Mr. Mazzamuto indicated that he "supervised employees 20 hours per week; 50% of the time, bookkeeping 10 hours per week; 25%

Exhibit F

of the time and other office duties 10 hours per week; 25% of the time." A copy of this form has been enclosed for your reference.

Mr. Mazzamuto and I spoke on the telephone on January 4, 2001. At this time, he indicated that he was owner of Vinny's Restaurant and that his duties were mostly managerial. He stated that he does the books, orders food, writes checks, etc. He had his workers to everything else such as cook, wait tables, etc. Mr. Mazzamuto indicated that he would very rarely help out with these duties. Only when someone didn't show up for work on short notice is when he would help out. The insured also stated that he was a very "nervous" person and that he thinks that he may have had too many years in the business. His wife and son are running the restaurant at this time.

On January 15, 2001, we forwarded an Occupational Description to our Mr. Mazzamuto for completion. This form was returned to our office on January 22, 2001. Mr. Mazzamuto indicated on this form that his duties consisted of bookkeeping 15-20% of the time, office duties 15-20% of the time and employee administration 50-60% of the time. A copy of this form has been enclosed for your reference.

Please note that you indicated to me that you do not feel that Mr. Mazzamuto's occupational description is correct. Mr. Mazzamuto has indicated numerous times throughout his claim file that his occupational duties consisted of office, executive and administration duties only. You stated that you know that "Mr. Mazzamuto is only one of two cooks." This appears to be contradictory to the statements and descriptions provided to us by Mr. Mazzamuto. Please also understand that Mr. Mazzamuto filed a disability claim with The New York Life Insurance Company in 1996. At this time, he indicated that again, his occupational duties consisted of office, executive and administration duties only.

You further mentioned that at the time of application for disability coverage in 1993, you recall that Mr. Mazzamuto's duties were more extensive and that he physically ran and operated the restaurant. Upon review of Mr. Mazzamuto's two applications for disability coverage, the first signed and dated by him on June 3, 1993 and the second on August 28, 1993, he specifically indicated that his duties consisted of "executive office duties only." Copies of these documents have been enclosed for your reference. You indicated that you may contact the writing agent to inquire as to why his duties were indicated as stated. Mr. Russo, please understand that regardless of what Mr. Mazzamuto's occupation and occupational duties were at the time of application, it is his duties at the time of claim for disability benefits that we would be evaluating.

On Mr. Mazzamuto's initial claim form, he indicated that he was unable to work as of Jul 29, 2000 due to a heart attack. Dr. Douglas Bower completed the Attending Physician's Statement portion of this form. He indicated that Mr. Mazzamuto's subjective symptoms were anxiety, worry, and low back pain. He restricted the insured from no prolonged standing and no heavy lifting (secondary to his back). Dr. Bower wrote that Mr. Mazzamuto's limitations were "cannot work in stressful situations." On the Medical Provider's Statement, also completed by Dr. Bower, he indicated that the insured also suffered an acute MI.

During my telephone conversation with Mr. Mazzamuto on January 4, 2001, he indicated that he suffered a heart attack in July 2000 and when the paramedics put him into the ambulance, his back "snapped." He stated that he has had a back condition for a number of years and this re-injured an injury that was "already there." As stated, his back problems have never went away and the ambulance occurrence "just made it worse." I asked the insured about his heart condition. He indicated that it was "better" and that he attended cardiac rehabilitation. Mr. Mazzamuto stated that it is his back condition that is restricting him from not returning to work. He indicated that there is a letter from his doctor regarding his back condition and requested that I telephone your office and ask "Melissa" to forward the letter to me.

I telephoned Melissa, per Mr. Mazzamuto's request, and she forwarded me a copy of a letter from Dr. Douglas Bower, via fax. The letter was dated on November 3, 2000, and indicated that Mr. Mazzamuto had a long history of low back pain. A MRI in the past revealed central spinal stenosis which gradually worsened to a maximum at the L3-L4 level and extends from L2-L5. Prolonged standing and heavy lifting aggravate it. He has been seen in physical therapy, treated in a pain clinic with local injections as well as prescription analgesics, nonsteroidal anti-inflammatory agents and other atypical chronic pain medications. Dr. Bower indicated that this condition was complicated when he was admitted to the hospital for his heart condition. He was readmitted to the hospital at a later date, with chest pain, and this pain was subsequently felt to be non-cardiac in nature. Dr. Bower further stated "as the patient has attempted to return to work after his recovery from his heart attack, his back has worsened again, also the stress and anxiety which has been provoked because of his recent cardiac problems, and manifested themselves with significant anxiety when he is back in a work situation." It was noted that Mr. Mazzamuto's heart condition was stabilized and should hopefully not pose a great limitation on him in the future. Dr. Bower stated "at the present time he is not able to do the work required in running his restaurant because he cannot stand for a prolonged period of time, has difficulty bending, and is restricted from heavy lifting.

Upon review of all additional medical documentation, it is noted that Mr. Mazzamuto was hospitalized on July 22, 2000 for the new onset of angina, with CPK evidence of a small subendocardial Myocardial Infarction. Cardiac Catheterization demonstrated a 90% distal LAD stenosis which was dilated to a 10% residual. Other stenoses included a 50% Dg1 and several 30-40% RCA narrowings. His ejection fraction was reported as 55%. He was readmitted several weeks later for recurrent chest pain, which was different from the pain of the MI and felt not to be cardiac in origin. On August 29, 2000, he had a stress echocardiogram test and walked for 7 minutes of the Bruce Protocol (approximately 10 METs), with a peak heart rate of 115 on beta blockers, an ejection fraction of 50% increasing with exercise, apical akinesis and no evidence of inducible ischemia. In an office note dated January 11, 2001, Dr. Bower indicated that Mr. Mazzamuto was doing well, and exercising without difficulty, but had continued back pain.

With respect to Mr. Mazzamuto's lower back pain, it appears that he has had a long history of lower back pain that has been treated with Neurontin, NSAIDs, Flexeril and epidural steroid injections, about twice yearly. A CT scan on September 15, 1992 reported spinal stenosis at the L3-4 level and

L4-5 level. Following a flare-up in pain after a fall on ice in 1996, a MRI on June 5, 1996 again reported the spinal stenosis at L3-4, felt to be developmental in origin, with no evidence of DJD or disc herniation. His pain at the time was described as burning located centrally in the lower back, extending down the lateral thighs to the knees. Although prolonged standing was said to lead to leg numbness, no abnormality on neurologic exam was reported. In an office visit September 22, 1997, Mr. Mazzamuto reported that his back was better but bothered him after three hours of standing.

Mr. Mazzamuto's back pain reportedly increased again following hitting a bump during his ambulance ride to the hospital in July 2000. His most recent epidural injections were on October 18, 2000 and January 31, 2001.

With respect to Mr. Mazzamuto's cardiac condition, there appears to be no information to support a cardiac impairment which would preclude work involving sedentary to light physical activity on a full-time (40 hour a week) schedule. His physician has restricted him from stressful situations, but there does not appear to be any information to support a present cardiac impairment related to stress, either terms of a significant stress-reduced rhythm disorder or angina.

Please also note, that we forwarded Mr. Mazzamuto's claim file to our Field Claim Representative, Mr. Brian Coar. Mr. Coar met with Mr. Mazzamuto at his home on April 4, 2001. During this interview, Mr. Mazzamuto indicated that he does not really have any pain in his heart anymore and that his shortness of breath concerns him. He also stated that he is afraid that if he goes back to work and is in a stressful situation, he may have another heart attack and die. He also indicated that some of his fear stems from the history of heart problems in his family. Please note that Mr. Mazzamuto's disability policy provides for benefits when he is unable to perform the duties of his occupation on either a full or part-time basis. His policy does not provide benefits in the event he may experience a condition which may cause a disability in the future.

With reference to Mr. Mazzamuto's claimed orthopedic condition, back pain, it is noted that he claims that the pain increases with prolonged standing and his physicians restrict him from prolonged standing or walking, heavy lifting, and bending. His job does not appear to involve heavy lifting (per Mr. Mazzamuto's statements). The degree to which he is required to stand or walk for a prolonged, uninterrupted periods of time, over 15-20 minutes at a time, is not clear. However, based on the insured's numerous occupational descriptions, it appears that his job duties are sedentary and light in nature. It should also be noted that his lower back pain tends to wax and wane and although he appears to have had prolonged exacerbation's after episodes of trauma (slipping on ice and a bump during an ambulance ride), the discomfort has subsided in the past, at least enough to return to work. Also, there does not appear to be any structural change in his condition associated with the recent exacerbation.

Based on all medical information in Mr. Mazzamuto's claim file, it does not appear that there are restrictions or limitations that would prevent Mr. Mazzamuto from working in his occupation on a full-time basis. Therefore, we find that he is ineligible for disability benefits under his contract.

However, if you would like to submit additional information for further consideration of his claim please send it to my attention. If you have no new information to provide but would like to appeal our determination, please send a written request for a review to:

UNUMProvident
Quality Performance Support
18 Chestnut Street
Worcester, MA 01608

Please be sure to include his social security number and claim number. Your written request should include your comments and views of the issues you wish UNUMProvident to consider. If UNUMProvident does not receive the written request within 90-days of the date of this notice, we will assume you agree with our determination.

Sincerely yours,

Melissa Magner

Melissa Magner, X6710
Claim Representative
The New York Life Insurance Company
UNUMProvident Corporation

Enc: copy of occ descriptions